STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E531	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kearny County Hospital Ltcu	607 Court Pl Lakin, KS 67860

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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. 51334 The facility reported a census of 25 residents. The sample included 12 residents. Based on interview and record review, the facility failed to treat residents in a dignified manner when it charted in the medical record that Resident (R)17 was placed at the feeder table. The facility did not honor resident's rights related to personal food preferences and food choices for Resident (R)124. This deficient practice placed the resident at risk for decreased psychosocial well-being. Findings included: - Review of the Electronic Health Record (EHR) revealed Resident (R)17 had the following diagnoses: pulmonary fibrosis (a process that causes lung scarring, in which fibrotic tissue blocks the movement of oxygen into the bloodstream and low oxygen levels), psychosis (any major mental disorder characterized by a gross impairment in reality perception), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and cognitive decline. Review of the 04/20/24 Annual Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) of 99, indicating the interview could not be completed. The resident was understood and rarely or never understands others. The staff interview of R17's cognition indicated the resident had memory problems. R17 knew the season, room location, and that she was in a nursing facility. R17's vision was moderately impaired, and hearing was highly impaired. The resident had an impairment to both arms, required set-up assistance with meals, and required oxygen. Review of the Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/24/24, revealed that physician documented R17 had declined in health status and required staff assistance for safety. Review of the Nutritional Status Care Area Assessment (CAA) dated 05/24/24, revealed that R17 ate poorly and often declined meals. (continued on next page)

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

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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	Review of the 07/23/24 Quarterly MDS revealed R17 had a Brief Interview for Mental Status (BIMS) score of 99, and the resident was understood and rarely or never understand. The MDS documented that the resident had memory problems. R17 knew that she was in a nursing facility, but did not know the season, room location, or staff. R17's vision was severely impaired and hearing was highly impaired. The resident required setup assistance with meals. Review of the Care Plan revealed on 07/19/23 the resident was independent with eating. The care plan was updated on 08/12/24 to include the resident required a divided plate to assist with meals. The 10/09/24 at 09:39 PM Health Status Note documented the resident sat at the feeders table due to hollering out about not being able to find things on the table. During an interview on 10/24/24 at 09:48 PM, Certified Medication Aide (CMA) R stated that residents should be referred to by their preferred name, never using labels, if another staff member is observed utilizing a label they should be immediately corrected and if the behavior persists then report to the charge nurse and/or DON. During an interview on 10/24/24 at 09:52 AM, Licensed Nurse G stated that residents should be referred to by their preferred name, never using labels, if another staff member is observed utilizing a label they should be immediately corrected and if the behavior persists then report to the charge nurse and/or DON. During an interview on 10/24/24 at 10:00 AM, Administrative Nurse D revealed she expected staff to refer to residents by their preferred name, never using labels in charting or in person. Administrative Nurse D said if another staff member was observed utilizing a label, they should be immediately corrected and if the behavior persisted then report to the charge nurse and/or DON. The facility's Dignity Policy approved October 2020 documented the facility will promote care in a manner that enhances each resident's dignity and respect in full recognition of their individuality. Staff will focus on each resident as an individual. The facility failed to provide Resident (R)17 care in a dignified manner when it referred to the table where the resident was placed as a feeder table in the electronic charting. This deficient practice placed the resident at risk for decreased psychosocial well-being.

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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** 50659 The facility reported a census of 25 residents, with 12 residents sampled and reviewed for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person could not make their own decisions). Based on interview and record review, the facility failed to ensure five resident's advanced directives were thoroughly completed. Resident (R)124 had a Do Not Resuscitate (DNR- or no code, a legal document that means the person does not desire cardiopulmonary resuscitation [CPR is an emergency lifesaving procedure performed when the heart stops beating] in the event of cardiac arrest) form that was only located in the Code Status binder at nurse's station. However, the electronic health record (EHR) lacked a DNR order and lacked the uploaded DNR document for R124. Additionally, R15 had no order for a DNR in the EHR. R21 and R20 had a durable power of attorney (DPOA-legal document that named a person to make healthcare decisions when the resident was no longer able to) signed DNR uploaded in the EHR, however, the EHR lacked an upload of the DPOA paperwork. R74 had no code order or scanned documents related to advanced directives in the EHR. Findings included: - During the onsite annual survey, a concern regarding advanced directives was identified for five of the 12 sampled residents. Review of the Electronic Health Records (EHR) on [DATE] revealed the following advanced directive concerns for the following five residents: R20 and R21 lacked documentation of the DPOA paperwork. R124 lacked a DNR order and lacked an uploaded DNR form. R15 lacked an order for DNR. R74 had no code order or scanned advanced directive documents. On [DATE], review of the Care Plan for R124, R74, R15, and R20 on [DATE] revealed lack of advanced directive information for each resident. On [DATE], the Physician Orders in the EHR lacked any orders for advanced directives for R124, R15, and R74. On [DATE], the EHR revealed a DNR signed by a family member and witnessed by Social Service Designee (SSD) X for R20 dated on [DATE] and for R21 dated [DATE]. During an observation on [DATE] at 08:53 AM, a butterfly sticker was noted above R21, R124, R20, and R15's bed on the light. (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 02:30 PM Licensed Nurse (LN) G reported a butterfly sticker was placed above the resident's bed, on the wall light, to alert staff the resident is a DNR. During an interview on [DATE] at 04:15 PM, Certified Nurse Aide (CNA) N reported she did not know what the butterfly sticker meant on a resident's light above their bed. During an interview on [DATE] at 08:35 AM, LN G reported that Social Service Designee (SSD) X would be responsible for completion of the advanced directive paperwork. The DNR order would be placed in EHR by a nurse. LN G reported that if a resident had a DNR form filled out, the paperwork was placed in the Code Status book located at the nurse's station. Additionally, the DNR form would be uploaded in the EHR, and a provider order would be written in the EHR. LN G confirmed R124 had a DNR form in the code status book, but no order in EHR or uploaded DNR form in EHR. During an interview on [DATE] at 08:42 AM, Administrative Nurse D reported if a resident had a DNR form, it would be uploaded in the EHR, and a provider order would be in the EHR. Administrative Nurse D reported that if the DNR was signed by the DPOA, that paperwork would need to be uploaded in the EHR also. During an interview on [DATE] at 09:03 AM, SSD X reported Administrative Nurse E would obtain a provider order for code status and place the order in EHR. SSD X revealed that she would complete the remainder of the advanced directive paperwork. SSD X confirmed R21 and R20's DPOA paperwork was not in uploaded in the EHR, and she could not locate the DPOA paperwork. SSD X reported that Administrative Staff B would have the required DPOA paperwork. SSD X reported she would sometimes not see the DPOA paperwork when the DNR was being signed by a DPOA and she would witness the DNR. SSD X confirmed that R124, R15 and R 74 lacked a provider order in EHR. During an interview on [DATE] at 09:35 AM, Administrative Staff B revealed R20 and R21 should have their DPOA paperwork uploaded in the EHR. Additionally, Administrative Staff B reported the EHR changed [DATE] and all the DPOA forms should be uploaded. She reported the EHR in the facility did not communicate with the EHR in the hospital. The facility's Advanced Directives policy dated [DATE], documented advanced directives are documents which state resident's choice about medical treatment, or name someone to make their decision about medical treatment for them if they are unable to make those decisions for themselves. If the resident states they have executed an advanced directive, ask them to supply a copy to be scanned in the EHR. If a resident does not have an advanced directive, educate them and provide resident and or surrogate with written information. The facility failed to ensure R124, R20, R21, R15, and R74 had accurate advanced directives completed. This deficient practice had the potential to lead to uncommunicated needs regarding the resident's choice in end-of-life care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46960 The facility reported a census of 25 residents. The sample included 12 residents. Based on observation and staff interviews, the facility failed to promote a clean homelike environment for five residents. Resident (8) had a chair seat repaired with duct tape and R124 had a bureau drawer, which had lacked part of the veneer on the drawer facing and the remaining veneer was loose and brittle. Additionally, R2, R74, R23 and R124 had fall mats, which were cracked and had worn down surfaces all that were identified as non-cleanable surfaces and a non-home-like environment. These deficient practices had the potential to spread possible infections to the residents in the facility. Findings included: During an observation on 10/23/24 at 01:21 PM. R124 had a fall mat on her floor in her room, which had several cracks, tears and worn-down surfaces. During an interview on 10/24/24 at 08:38 AM, Housekeeping Staff II reported she would clean the fall mats with disinfectant cleaner and that it was not her job to report the fall mat that were worn down. Housekeeping Staff II reported she would only replace a cracked or torn pillow. During an interview on 10/24/24 at 09:00 AM, Housekeeping Supervisor W confirmed the fall mat was a non-cleanable surface and Housekeeping Staff should report equipment that is worn down, cracked, or torn to provide a home-like environment. During an observation on 10/24/24 at 11:01 AM, an environmental tour was completed with Maintenance Director JJ and Administrative Nurse D, which revealed R8 had a chair seat that was repaired with duct tape, Maintenance Director JJ reported that chair belonged to R8. Administrative Nurse D confirmed the chair was an un-cleanable surface and not a home-like environment. R74, R23 and R2's rooms had fall mats which were cracked and had worn surfaces, identified by Administrative Nurse D and Maintenance Director JJ as non-cleanable surfaces and non-home-like environment. Additionally, R124 had a bureau drawer that lacked part of the veneer on the drawer facing and what remained of the veneer was loose and brittle, identified by Administrative Nurse D and Maintenance Director JJ as a non-cleanable, accident hazard and non-home-like environment. The facility lacked a policy on clean home-like environment. The facility failed to promote a clean homelike environment for five residents R2, R8, R23, R74 and R124. These deficient practices had the potential to spread possible infections to the residents in the facility and had the potential to lead to negative psychosocial effects related to non-home-like environment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility had a census of 25 residents. The sample included 12 residents with three reviewed for discharge. Based on observation, interview, and record review the facility failed to provide written notice to the resident or resident representative for facility-initiated transfers for Residents (R)18, R12, and R23 when they transferred to the hospital. The facility also failed to send a copy of the notice to the Office of the Long-Term Care Ombudsman (LTCO - a public official who works to resolve resident issues in nursing facilities) of R18, R12, or R23's discharge. This placed the residents at risk of uninformed care choices. Findings included: - Review of the Electronic Health Record (EHR) census log for R18 revealed a discharge from the facility to a hospital on 04/23/24 and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative or notification of the LTCO related to this discharge/transfer. Review of the EHR census log for R12 revealed a discharge from the facility to a hospital on 01/14/24 and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative or notification of the LTCO related to the discharge/transfer. Review of the EHR census log for R23 revealed a discharge from the facility to a hospital on 09/23/24 and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative, or evidence the facility sent a copy of the notification to the LTCO related to this discharge/transfer. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D revealed that Social Services Designee (SSD) X was responsible for the discharge notifications and did not know if SSD X notified the LTCO for discharges. During an interview on 10/23/24 at 11:03 AM, SSD X revealed she did not know of the regulatory requirement to notify the resident or resident's representative or the LTCO in writing of discharges from the facility. The facility did not provide a policy related to discharge notifications as requested on 10/24/24. The facility failed to provide written notification of facility-initiated discharges/transfers to the resident or resident's representative, or the LTCO. This placed the residents at risk of uninformed care choices.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility had a census of 25 residents. The sample included 12 residents with three reviewed for discharge. Based on observation, record review, and interviews, the facility failed to provide a written bed hold policy notice to Residents (R)18, R12, and R23, or the resident's representatives, when they transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R18, R12 and R23. Findings included: - Review of the Electronic Health Record (EHR) census log for R18 revealed a discharge from the facility to a hospital on 04/23/24 and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative or notification of the LTCO related to this discharge/transfer. Review of the EHR census log for R12 revealed a discharge from the facility to a hospital on 01/14/24 and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative or notification of the LTCO related to the discharge/transfer. Review of the EHR census log for R23 revealed a discharge from the facility to a hospital on 09/23/24 and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative, or evidence the facility sent a copy of the notification to the LTCO related to this discharge/transfer. During an interview on 10/23/24 at 09:14 AM Licensed Nurse (LN) G revealed that when a resident goes to the hospital, Social Services Designee (SSD) X handled the bed hold process During an interview on 10/23/24 at 11:03 AM, SSD X revealed she did not know of the regulatory requirement to notify the resident or resident's representative in writing of a bed hold notice with discharges from the facility. SSD X stated the bed hold policy is only reviewed with residents and their representatives during the admission process. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D revealed SSD X was responsible for the discharge notifications and was unaware of the regulatory requirement that residents or resident's representatives were to be notified in writing with a bed hold notice. Administrative Nurse D stated SSD X discussed the bed hold policy with the resident or resident's representative with each new admission and she was unaware if the bed hold policy/notice was discussed with the residents or resident's representative at the time of a transfer/discharge. The facility did not provide a policy related to written bed hold notifications as requested on 10/24/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide written notification of the facility's bed hold policy to the resident or resident's representative with facility-initiated discharges/transfers. This placed the residents at risk of an impaired ability to return to the facility and to the previous room for R18, R12 and R23.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 25 residents. The sample included 12 residents reviewed for person-centered care plan development. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan for three residents, Resident (R) 74 related to psychotropic (any class of medications that alter mood or thought) medication use, opioid (a class of medications used to treat moderate to severe pain) medication use, diuretic (a class of medication to promote the formation and excretion of urine) medication use and nebulized (a device which changes liquid medication into a mist easily inhaled into the lungs) medication use. R124's Care plan lacked interventions related to the performance (or lack thereof) for activities of daily living (ADLs - activities such as walking, grooming, toileting, dressing and eating, etc.), psychotropic medication use, visual function, abnormal behaviors, nutritional status, and pain. R20's care plan lacked interventions to mitigate the risk for falls with a known history of falls. These deficient practices had the potential to lead to uncommunicated needs which would negatively impact the physical and psychosocial well-being of the residents. Findings Included: - R74's Electronic Health Record (EHR) revealed diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid) and Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure) The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The assessment documented R74 utilized a walker and/or a wheelchair for locomotion. The resident received antianxiety (a class of medications that calm and relax people) medications, antidepressant (a class of medications used to treat mood disorders) medications, diuretic medications and opioid medications. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/15/24 documented R74 had periods of confusion. The Psychotropic Drug Use CAA dated 10/15/24 documented R74 had no prescribed antidepressant medication. The Pain CAA was not triggered on the assessment. The Physician Orders revealed the following orders: Ativan (lorazepam, a benzodiazepine class of medication which works on the neurotransmitters in the brain and is used to treat anxiety) 0.5 milligram (mg), give 0.5 mg every eight hours PRN for anxiety, dated 10/01/24. The order lacked a stop date or rationale for the continued use of the medication. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Norco (hydrocodone-acetaminophen - an opioid pain medication) 5-325 milligrams (mg), one tablet by mouth (PO) every 12 hours PRN pain, dated 10/01/24. Ipratropium Bromide (a nebulized medication) inhalation solution 0.02 percent (%), one vial to be inhaled orally every six hours related to diagnosis of COPD. Furosemide (a diuretic medication) 20mg, PO every day related to diagnosis of CHF. Duloxetine HCl (an antidepressant medication) 30mg, PO daily related to diagnosis of anxiety/depression. Review of the Census tab on the EHR revealed that R74 admitted to the facility on [DATE]. Review of the electronic Medication Administration Record (eMAR) from 10/01/24 to 10/23/24 revealed R74 had not received any doses of PRN Ativan (lorazepam) and lacked evidence of an ordered stop date. The eMAR documented appropriate doses of the antidepressant, nebulized, and diuretic medications. During an observation on 10/21/24 at 04:41 PM, R74 sat in his recliner, watching television and appeared relaxed and calm. During an observation on 10/22/24 at 12:14 PM, R74 sat in his wheelchair at a table in the dining area with peers present and appeared relaxed and calm. During an interview on 10/23/24 at 08:49 AM, Certified Nurse Aide (CNA) O revealed resident specific cares were reported from one shift to the next during the end-of-shift report and further stated there was a book with interventions at the nurse's station, but it was not updated anymore. During an interview on 10/23/24 at 01:33 PM, Administrative Nurse D stated residents who use nebulized medications should include interventions specific to care of the equipment, additionally any medications that required additional monitoring (such as black-box warnings related to psychotropics, opioids, diuretics) were documented in the EHR next to the actual order. Administrative Nurse D confirmed that R74's care plan lacked information related to psychotropic, diuretic, opioid, or nebulized medication use. The facility failed to provide a policy related to person-centered care plan development/implementation as requested on 10/24/24. The facility failed to develop and implement a person-centered comprehensive care plan for R74 related to psychotropic medication, diuretic medication, or nebulized medication use. This deficient practice had the potential to lead to uncommunicated needs which had the potential to negatively affect the physical and psychosocial well-being of R74. 50659 The facility reported a census of 25 residents. The sample included 12 residents. Based on medical record review and staff interviews, the facility failed to complete Care Area Assessments that addressed the individual underlying causes, contributing factors and risk factors for six residents. Resident (R)8, R12, R17, R18, R74 and R124 had incomplete, or no CAA notes completed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Findings included: - During the onsite annual survey, a concern regarding the facility gathered and analyzed supplemental information based on the triggered CAAs prior to developing the comprehensive care plan was identified for six of the 12 sampled residents. Review of the Electronic Health Record (EHR) on 10/21/24 revealed the following CAA noted concerns for the following six residents: The 02/29/24 Annual Minimum Data Set (MDS) for R8 completed on 08/13/24, with incomplete analysis of Functional Abilities CAA documented R8 depends on staff for all cares. The 09/04/23 Annual MDS for R12 completed on 09/18/23, with no CAA notes completed in all of the areas triggered which included: Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Activities, Psychosocial Well Being, Falls, Visual Function, Mood State, Pressure Ulcer/Injury, Psychotropic Drug Use and ADL Functional/ Rehab Potential. The 04/20/24 Annual MDS for R17 completed on 05/24/24, with incomplete analysis of Psychotropic Drug Use CAA documented related to decline in condition, physician has increased her dose. The Falls CAA documented R17 had actual falls with no injury. The 04/22/24 Annual MDS for R18 completed on 08/16/24, with incomplete analysis of Falls CAA documented R18 is a high risk for falls related to seizure activity and behaviors. The 10/14/24 Admission MDS for R74 completed on 10/15/24, with incomplete analysis of Functional Abilities CAA documented R74 was able to go care by self with minimal staff assistance. The Psychotropic Drug Use documented R74 had no prescribed antidepressants. The 09/29/24 Admission MDS for R124 had no date for completion of the MDS, the CAA or submission record as of 10/21/24. Administrative Nurse E (MDS Nurse) confirmed during an interview on 10/23/24 at 04:00 PM an issue with EHR submission and reported that R124's CAAs were completed. Review of the following CAA's were documented with incomplete analysis. The Cognitive Loss/Delirium CAA documented R124 had a history of cognitive loss and dementia with impaired decision making for her safety. The Psychotropic Drug Use CAA documented R124 received medication as prescribed. The Dental CAA documented R124's bridges are broken related to her las injury fall. The Falls CAA documented R124 has a history of falls with the last having significant injuries. The Nutritional CAA documented not an issue with R124 at this time. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E (MDS Nurse) confirmed the CAA Notes that were not completed or lacked analysis and risk findings. Administrative Nurse E revealed she was unsure on what to write for CAA notes. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. (continued on next page)

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	17E531	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kearny County Hospital Ltcu	607 Court Pl Lakin, KS 67860

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to accurately complete the CAAs for R8, R12, R17, R18, R74 and R124 related to several CAAs triggered. This placed the residents at risk for uncommunicated care needs.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 25 residents. The sample included 12 residents. Based on interview and record review, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment in a timely manner for eight residents, Resident (R) 8, R10, R12, R17, R18, R19, R20 and R21. This placed the residents at risk for unmet care needs and inaccurate assessments. Findings included: - During the onsite annual survey, the surveyor identified a concern regarding the lack of quarterly MDS assessments completed in a timely manner for eight residents. Review of the Electronic Health Record (EHR) on 10/21/24 revealed the following quarterly MDS noted concerns for the following eight residents: R8's EHR recorded a quarterly MDS, dated [DATE]. R8's EMR recorded the quarterly MDS, dated [DATE], was completed on 09/26/24 and submitted on 09/26/24. (11 days later) R10's EHR recorded a quarterly MDS, dated [DATE]. R10's EMR recorded the quarterly MDS, dated [DATE], was completed on 09/26/24 and submitted on 09/26/24. (10 days later) R12's EHR recorded a quarterly MDS, dated [DATE]. R12's EMR recorded the quarterly MDS, dated [DATE], was completed on 07/09/24 and submitted on 07/10/24. (16 days later) R17's EHR recorded a quarterly MDS, dated [DATE]. R17's EMR recorded the quarterly MDS, dated [DATE], was completed on 09/04/24 and submitted on 09/04/24. (34 days later) R18's EHR recorded a quarterly MDS, dated [DATE]. R18's EMR recorded the quarterly MDS, dated [DATE], was completed on 08/16/24 and submitted on 08/16/24. (10 days later) R19's EHR recorded a quarterly MDS, dated [DATE]. R19's EMR recorded the quarterly MDS, dated [DATE], was completed on 09/04/24 and submitted on 09/04/24. (36 days later) R20's EHR recorded a quarterly MDS, dated [DATE]. R20's EMR recorded the quarterly MDS, dated , d+[DATE]//24, was in progress but not completed or submitted as required. (11 days late) R21's EHR recorded a quarterly MDS, dated [DATE]. R21's EMR recorded the quarterly MDS, dated , d+[DATE]//24, was completed on 10/22/24 and submitted on 10/23/24. (16 days later) During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E, the facility's MDS Nurse, confirmed that quarterly MDS assessments were in progress or completed late. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. MDS assessments will be completed and submitted according to the regulatory time periods. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to complete a Quarterly Minimum Data Set (MDS) assessment in a timely manner for eight residents, R8, R10, R12, R17, R18, R19, R20, and R21. This placed the residents at risk for unmet care needs and inaccurate assessments.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 25 residents. The sample included 12 residents. Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment in a timely manner for ten residents. Resident (R)8, R10, R12, R15, R17, R18, R19, R20, R21 and R124. This placed the residents at risk for unmet care needs and inaccurate assessments. Findings included: - During the onsite annual survey, the surveyor identified a concern regarding the lack of comprehensive MDS assessments completed in a timely manner for ten residents. Review of the Electronic Health Record (EHR) on 10/21/24 revealed the following comprehensive MDS noted concerns for the following 10 residents: R8's EHR recorded a comprehensive MDS, dated [DATE]. R8's EMR recorded an Annual MDS, dated [DATE], was completed on 08/13/24 and submitted on 08/14/24. (167 days later) R10's EHR recorded a comprehensive MDS, dated [DATE]. R10's EMR recorded an Annual MDS, dated [DATE], was completed on 05/10/24 and submitted on 05/22/24. (82 days) R12's EHR recorded a comprehensive MDS, dated [DATE]. R12's EMR recorded an Annual MDS, dated [DATE], the EHR lacked an Annual MDS for 09/04/24. (366 days) R15's EHR recorded a comprehensive MDS, dated [DATE]. R15's EMR recorded an Admission MDS, dated [DATE], was completed on 08/27/24 and submitted on 08/27/24. (181 days) R17's EHR recorded a comprehensive MDS, dated [DATE]. R17's EMR recorded an Annual MDS, dated [DATE], was completed on 05/24/24 and submitted on 05/31/24. (41 days) R18's EHR recorded a comprehensive MDS, dated [DATE]. R18's EMR recorded an Annual MDS, dated [DATE], was completed on 08/16/24 and submitted on 08/16/24. (116 days) R19's EHR recorded a comprehensive MDS, dated [DATE]. R19's EMR recorded an Annual MDS, dated [DATE], was completed on 11/01/23 and submitted on 11/01/23. (18 days) R20's EHR recorded a comprehensive MDS, dated [DATE]. R20's EMR recorded an Annual MDS, dated [DATE], was completed on 06/22/24 and submitted on 06/24/24. (184 days) R21's EHR recorded a comprehensive MDS, dated [DATE]. R21's EMR recorded an Annual MDS, dated [DATE], was completed on 08/21/24 and submitted on 08/21/24. (60 days) R124's EHR recorded a comprehensive MDS, dated [DATE]. R124's EMR recorded an Admission MDS, dated [DATE], was in progress but not completed or submitted as required. (22 days) (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E, the facility's MDS Nurse, confirmed that comprehensive MDS assessments were in progress or completed late. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. MDS assessments will be completed and submitted according to the regulatory time periods. The facility failed to complete a comprehensive MDS assessment in a timely manner for ten residents. Resident (R)8, R10, R12, R15, R17, R18, R19, R20, R21 and R124. This placed the residents at risk for unmet care needs and inaccurate assessments.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 25 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the [NAME] Data Set for seven residents: Resident (R) 12, R17, R18, R21, and R20 related to falls; R21 related to antipsychotic medication; R20 related to chair alarm; R74 related to antidepressant medication; and R8 related to antiplatelet medications. This placed the residents at risk for uncommunicated care needs. Findings included: - The Electronic Health Records (EHR) documented R21 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), degenerative arthritis (a chronic condition that causes cartilage in the joints to break down over time) of bilateral (both sides) knees and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). The 06/22/24 Annual Minimum Data Set (MDS) documented R21 had two non-injury falls from 03/24/24 thru 06/22/24 and received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressants (class of medications used to treat mood disorders) medications during the lookback period for seven days 06/16/24 thru 06/22/24. The 08/21/24 Falls Care Area Assessment (CAA) documented R21 was at risk for falls due to a history of falling and she was unsteady on her feet, mixed with her confusion at times. The 08/21/24 Psychotropic Drug Use CAA documented R21 required several medications to control her mental health diagnosis. The 04/27/24 at 02:31 AM Progress Note revealed staff found R21 on the floor in her bathroom. The note documented R21 had severe swelling noted on the right side of her face with lesions noted on her lower lip with severe bleeding. The note included R21 had bruising noted on the back of her right and left hands and both arms, and she transferred to the hospital. The 04/27/24 at 04:39 AM Progress Note revealed R21 returned from the hospital, and R21 had fractures of the sinus bones and a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to her right cheek. The 06/01/24 through 06/22/24 Medication Administration Record lacked evidence of any antipsychotic medications administered to R21. During an observation on 10/21/24 at 03:54 PM, R21 sat in her recliner with a seated rolling unlocked walker in front of her. She was very hard of hearing and had bilateral hearing aids in her ears. R21 had a hard time expressing her thoughts, as she stuttered and repeated her words. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E MDS Nurse confirmed R21's Annual MDS was incorrect. Administrative Nurse E stated R21 had not received an antipsychotic medication and had a major injury fall during the lookback period of the Annual MDS completed in June 2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. The facility failed to accurately complete the MDS for (R)21 related to falls and antipsychotic medications. This placed the resident at risk for uncommunicated care needs. - Resident (R) 20's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion) and parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The 12/23/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R20 had a total mood severity score of six, which indicated mild depression. R20 required set up assistance for eating and required moderate assistance with activities of daily living (ADLs) to include dressing, toileting hygiene, footwear, personal hygiene, and standing. R20 required supervision for ambulation, oral care, and transfers. R20 had two or more non-injury falls. The 06/22/24 Falls Care Area Assessment (CAA) documented R20 had a fall history and had falls while in facility. The 06/26/24 Quarterly MDS documented R20 had two or more non-injury falls from 03/26/24 through 06/26/24 and R20 had a chair alarm in the look back period of seven days from 06/20/24 through 06/26/24. The 10/21/24 Care Plan lacked any documentation for the resident's chair alarm. The 04/08/24 at 02:15 AM Progress Note revealed staff found R20 lying on his right side, on the floor, in front of his bathroom. R20 reported he fell and was not using his walker. The 04/09/24 at 09:32 PM Progress Note revealed bruising noted on right wrist and hand from previous fall. During an observation on 10/21/24 at 04:00 PM and 05:12 PM, R20 was seated in his lift chair in his room, the lift chair was approximately a quarter to halfway lifted and R20 was leaning towards the floor. No chair alarm was noted on recliner or in the resident's room. During an interview on 10/23/24 at 08:26 AM, CNA M reported that R20 never had a personal alarm on his chair or any dycem noted on the seat of his recliner. CNA M reported R20 could use his left chair remote independently. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E MDS Nurse confirmed R20's Quarterly MDS was incorrect. Administrative Nurse E stated R20 had a minor injury fall during the lookback period of the Quarterly MDS completed in June 2024 and did not have a chair alarm. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. The facility failed to accurately complete the MDS for (R)20 related to falls and chair alarm. This placed the resident at risk for uncommunicated care needs. 46960 - R74's Electronic Health Record (EHR) revealed diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid) and Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure) The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The assessment documented R74 utilized a walker and/or a wheelchair for locomotion. The assessment documented the resident received antianxiety (a class of medications that calm and relax people) medications, antidepressant (a class of medications used to treat mood disorders) medications, diuretic medications, and opioid medications even though the resident's record lacked evidence the resident received all of these medications during the lookback period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/15/24 documented R74 had periods of confusion. The Psychotropic Drug Use CAA dated 10/15/24 documented R74 had no prescribed antidepressant medication. The Pain CAA was not triggered on the assessment. The Physician Orders revealed the following orders: Ativan (lorazepam, a benzodiazepine class of medication which works on the neurotransmitters in the brain and is used to treat anxiety) 0.5 milligram (mg), give 0.5 mg every eight hours PRN for anxiety, dated 10/01/24. The order lacked a stop date or rationale for the continued use of the medication. Norco (hydrocodone-acetaminophen - an opioid pain medication) 5-325 milligrams (mg), one tablet by mouth (PO) every 12 hours PRN pain, dated 10/01/24. Ipratropium Bromide (a nebulized medication) inhalation solution 0.02 percent (%), one vial to be inhaled orally every six hours related to diagnosis of COPD. Furosemide (a diuretic medication) 20mg, PO every day related to diagnosis of CHF. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Duloxetine HCl (an antidepressant medication) 30mg, PO daily related to diagnosis of anxiety/depression. Review of the Census tab on the EHR revealed that R74 admitted to the facility on [DATE]. Review of the electronic Medication Administration Record (eMAR) from 10/01/24 to 10/23/24 revealed R74 had not received any doses of PRN Ativan (lorazepam) and lacked evidence of an ordered stop date. The eMAR documented R74 had not received any doses of the opioid pain medication. The eMAR documented appropriate doses of the antidepressant, nebulized, and diuretic medications. During an observation on 10/21/24 at 04:41 PM, R74 sat in his recliner, watching television and appeared relaxed and calm. During an observation on 10/22/24 at 12:14 PM, R74 sat in his wheelchair at a table in the dining area with peers present and appeared relaxed and calm. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. The facility failed to accurately complete the MDS for R74 related to documentation of psychotropic and opioid medication use, when the resident did not utilize those medications during the lookback period. This placed the resident at risk for uncommunicated care needs. - Review of the Electronic Health Record (EHR) for Resident (R) 18 included diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion), epilepsy (a brain disorder characterized by repeated seizures), and frontotemporal neurocognitive disorder (a brain disease that affects behavior, language, and movement abilities). The 04/22/24 Annual Minimum Data Set (MDS) completed 08/16/24, documented the Brief Interview for Mental Status (BIMS) assessment could not be completed, and the staff assessed R18 to have severely impaired cognition. The assessment documented R18 displayed no behaviors, utilized a wheelchair for locomotion and was dependent on staff for all cares except oral hygiene, which required substantial/maximum assistance and eating which required partial/moderate assistance. The assessment documented R18 had two or more falls since admission or the previous assessment, which included one fall with major injury. The 07/23/24 Quarterly MDS completed 08/16/24, documented the Brief Interview for Mental Status (BIMS) assessment could not be completed and the staff assessed R18 to have severely impaired cognition. The assessment documented R18 experienced hallucinations (sensing things while awake that appear to be real, but the mind created), displayed physical and verbal behavioral symptoms directed towards others one to three days during the seven-day look-back period. R18 utilized a walker and/or wheelchair for locomotion and was dependent on staff for all cares except eating, which required partial/moderate assistance from staff. The assessment documented no falls since admission or the previous assessment. The Progress Notes and fall investigation reports identified two falls which were not identified on the 07/23/24 Quarterly MDS that was completed on 08/16/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/23/24 at 04:00 PM with Administrative Staff A and Administrative Nurse E (MDS Nurse), confirmed R18's Quarterly MDS was inaccurate related to falls and confirmed that R18 had a fall that should have been captured during the 90-day look-back period between the Annual MDS dated [DATE] and the Quarterly MDS dated [DATE]. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. The facility failed to accurately complete the MDS for R18 related to falls and antipsychotic medications. This placed the resident at risk for uncommunicated care needs. - Review of the Electronic Health Record (EHR) for Resident (R) 8 included the diagnosis of atrial fibrillation (a rapid irregular heartbeat). The 02/29/24 Annual Minimum Data Set (MDS) completed 08/13/24 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented that R8 was dependent on staff for all cares except hygiene, which required partial/moderate assistance and eating which required supervision and setup and R8 received oxygen. The assessment documented that R8 did not receive an antiplatelet (a class of medication that prevents blood clot formation) medication. The EHR Physician Orders documented an order for clopidogrel bisulfate (an antiplatelet medication), 75 milligrams (mg), give one tablet by mouth (PO) once daily related to diagnosis of atrial fibrillation, dated 10/02/23. Review of the electronic medication administration record (eMAR) from 02/01/24 to 02/29/24 documented appropriate documentation of administration of medication, which included clopidogrel bisulfate as ordered by the physician. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E (MDS Nurse) confirmed R8's Annual MDS was incorrect. Administrative Nurse E stated R8 had received an antiplatelet medication during the seven-day look-back period of the Annual MDS completed on 08/13/24. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. The facility failed to accurately complete the MDS for R8 related to antiplatelet medications. This placed the resident at risk for uncommunicated care needs. 51334 - Review of the 04/20/24 Annual Minimum Data Set (MDS) documented R17 had two or more noninjury falls from 01/21/24 thru 04/20/24. Review of the Progress Notes from 01/21/24 thru 04/20/24 revealed no falls during this time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the 07/23/24 Quarterly Minimum Data Set revealed R17 had two or more noninjury falls from 04/22/24 thru 07/23/24 and was not taking and antibiotic medication. However, the Incident Note on 06/17/24 at 12:00 AM documented R17 had a fall with no injury. The Health Status Note on 06/13/24 at 12:22 PM documented R17 was sent to the emergency room and returned and started on an antibiotic and a steroid treatment. Review of the Physician Orders in the EHR documented an order for amoxicillin 500 milligrams (mg) to be taken three times a day for 10 days. Started on 07/10/24 and finished on 07/20/24. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E MDS Nurse confirmed R17's Annual MDS was incorrect. Administrative Nurse E stated R17 had no falls during the lookback period of the Annual MDS for April 2024 and confirmed the Quarterly MDS was incorrect because R17 had received an antibiotic medication and had one fall with minor injury during the lookback period of the Quarterly MDS for July 2024. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's current status. The facility failed to accurately complete the MDS for (R)17 related to falls and antibiotic medications. This placed the resident at risk for uncommunicated care needs. - Review of the 09/04/23 Annual Minimum Data Set (MDS) documented R12 had no falls from 06/09/23 thru 09/04/23. However, Incident Note revealed R12 fell on the following dates: 06/26/23, 07/19/23, and 09/19/23. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E MDS Nurse confirmed R12's Annual MDS was incorrect. Administrative Nurse E stated R12 had two falls with no injury and one fall will minor injury on the 09/04/23 Annual MDS. Administrative Nurse E confirmed R12's Quarterly MDS was incorrect. R12 had one fall will minor injury on the 06/06/24 Quarterly MDS. The facility's policy RAI and CAA Completion dated 10/2020, documented the purpose of the Resident Assessment Instrument is to assist the facility in providing appropriate care to residents. The assessment must accurately reflect the resident's status. The facility failed to accurately complete the MDS for (R)12 related to falls. This placed the resident at risk for uncommunicated care needs.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 25 residents with 12 residents sampled that included two residents reviewed for baseline care plan. Based on interviews, observations, and record review, the facility failed to develop a person-centered baseline care plan for Resident (R) 74 and R124. This deficient practice had the potential to lead to uncommunicated needs. Findings included: - The Electronic Health Record (EHR) census for Resident (R) 74 revealed that R74 was admitted to the facility on [DATE] and the EHR lacked documentation that a baseline care plan was created. Further, R74's permanent person-centered comprehensive care plan was completed on 10/15/24 (15 days after the admission). The EHR census log for R124 revealed R124 admitted to the facility on [DATE] and the EHR lacked documentation that a baseline care plan was created. R124's permanent person-centered comprehensive care plan was created on 09/17/24 but lacked initial goals based on admission orders, physician's orders, therapy services, social services and if applicable a PASARR (Preadmission Screening and Resident Review - a federal requirement to help ensure that individuals with mental illness or intellectual/developmental disability were not inappropriately placed in nursing homes for long term care) recommendation, as required. During an interview on 10/23/24 at 02:40 PM, Administrative Nurse D stated that she was unaware of what a baseline care plan was or who was responsible for the completion of a baseline care plan. Administrative Nurse D stated she was unaware of the regulatory requirement for the completion of a baseline care plan within the first 48 hours of admission, or the completion of a comprehensive person-centered care plan within the first 48 hours of admission. The facility failed to complete a baseline care plan for R74 and R124. This deficient practice had the potential to lead to uncommunicated needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 25 residents. The sample included 12 residents reviewed for person-centered care plan development. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan for three residents, Resident (R) 74 related to psychotropic (any class of medications that alter mood or thought) medication use, opioid (a class of medications used to treat moderate to severe pain) medication use, diuretic (a class of medication to promote the formation and excretion of urine) medication use and nebulized (a device which changes liquid medication into a mist easily inhaled into the lungs) medication use. R124's Care plan lacked interventions related to the performance (or lack thereof) for activities of daily living (ADLs - activities such as walking, grooming, toileting, dressing and eating, etc.), psychotropic medication use, visual function, abnormal behaviors, nutritional status, and pain. R20's care plan lacked interventions to mitigate the risk for falls with a known history of falls. These deficient practices had the potential to lead to uncommunicated needs which would negatively impact the physical and psychosocial well-being of the residents. Findings Included: - R74's Electronic Health Record (EHR) revealed diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid) and Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure) The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The assessment documented R74 utilized a walker and/or a wheelchair for locomotion. The resident received antianxiety (a class of medications that calm and relax people) medications, antidepressant (a class of medications used to treat mood disorders) medications, diuretic medications and opioid medications. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/15/24 documented R74 had periods of confusion. The Psychotropic Drug Use CAA dated 10/15/24 documented R74 had no prescribed antidepressant medication. The Pain CAA was not triggered on the assessment. The Physician Orders revealed the following orders: Ativan (lorazepam, a benzodiazepine class of medication which works on the neurotransmitters in the brain and is used to treat anxiety) 0.5 milligram (mg), give 0.5 mg every eight hours PRN for anxiety, dated 10/01/24. The order lacked a stop date or rationale for the continued use of the medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Norco (hydrocodone-acetaminophen - an opioid pain medication) 5-325 milligrams (mg), one tablet by mouth (PO) every 12 hours PRN pain, dated 10/01/24. Ipratropium Bromide (a nebulized medication) inhalation solution 0.02 percent (%), one vial to be inhaled orally every six hours related to diagnosis of COPD. Furosemide (a diuretic medication) 20mg, PO every day related to diagnosis of CHF. Duloxetine HCl (an antidepressant medication) 30mg, PO daily related to diagnosis of anxiety/depression. Review of the Census tab on the EHR revealed that R74 admitted to the facility on [DATE]. Review of the electronic Medication Administration Record (eMAR) from 10/01/24 to 10/23/24 revealed R74 had not received any doses of PRN Ativan (lorazepam) and lacked evidence of an ordered stop date. The eMAR documented appropriate doses of the antidepressant, nebulized, and diuretic medications. During an observation on 10/21/24 at 04:41 PM, R74 sat in his recliner, watching television and appeared relaxed and calm. During an observation on 10/22/24 at 12:14 PM, R74 sat in his wheelchair at a table in the dining area with peers present and appeared relaxed and calm. During an interview on 10/23/24 at 08:49 AM, Certified Nurse Aide (CNA) O revealed resident specific cares were reported from one shift to the next during the end-of-shift report and further stated there was a book with interventions at the nurse's station but it was not updated anymore. During an interview on 10/23/24 at 01:33 PM, Administrative Nurse D stated residents who use nebulized medications should include interventions specific to care of the equipment, additionally any medications that required additional monitoring (such as black-box warnings related to psychotropics, opioids, diuretics) were documented in the EHR next to the actual order. Administrative Nurse D confirmed that R74's care plan lacked information related to psychotropic, diuretic, opioid, or nebulized medication use. The facility failed to provide a policy related to person-centered care plan development/implementation as requested on 10/24/24. The facility failed to develop and implement a person-centered comprehensive care plan for R74 related to psychotropic medication, diuretic medication, or nebulized medication use. This deficient practice had the potential to lead to uncommunicated needs which had the potential to negatively affect the physical and psychosocial well-being of R74.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50659 - Resident (R) 20's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion), and parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The 12/23/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R20 had a total mood severity score of six, which indicated mild depression. R20 required set up assistance for eating and required moderate assistance with activities of daily living (ADLs) to include dressing, toileting hygiene, footwear, personal hygiene, and standing. R20 required supervision for ambulation, oral care, and transfers. R20 had two or more non-injury falls. The 06/22/24 Falls Care Area Assessment (CAA) documented R20 had a fall history and had falls while in facility. The 06/22/24 Cognitive Loss/Dementia CAA documented R20 required staff cues and assistance with ADL's and decisions for safety based on cognitive decline. The 06/26/24 Quarterly MDS documented a BIMS score of two, indicating severely impaired cognition. R20's total mood severity score of five, indicated mild depression. R20 required set up assistance for eating and required supervision assistance for oral care, transfers, and ambulation. R20 required maximal assistance with toileting hygiene, dressing, and standing. The resident had two or more non-injury falls and had a chair alarm. The 10/21/24 Care Plan documented fall prevention interventions, initiated 05/15/23, which included staff were instructed to provide a safe environment with adequate low glare light, ensure the resident's bed was in the lowest position and ensure the wheels were locked on bed. The 10/21/24 Care Plan documented following fall prevention interventions, initiated 03/15/24, which included staff were instructed to determine and address causative factors of falls and follow facility post-fall policy regarding monitoring signs and symptoms of injury post fall. The 10/21/24 Care Plan lacked any documentation for the resident's chair alarm and any new fall interventions for the falls that occurred on 03/12/24 (two falls), 04/08/24, 06/05/24, 06/19/24, 06/22/24, 08/01/24, 08/06/24, and 08/28/24. The 10/21/24 Physician Orders lacked any documentation regarding falls or a chair alarm. The 03/12/24 at 02:24 AM Progress Note revealed staff found R20 on the floor leaning towards his left side, in front of his recliner. The lift chair was all the way up and his walker was approximately three feet away. R20 had socks on his feet and reported he slipped when he tried to get up to go to the bathroom. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The fall that occurred on 03/12/24 at 02:24 AM, lacked an intervention and lacked a Risk Management Report. The 03/12/24 at 01:18 PM Progress Note revealed the resident had a witnessed fall, R20 ambulated independently in the dining room without his walker, bent over to pick up a cane on the floor, fell forward, and struck his head, which caused an abrasion to the top of his head. The Risk Management Report dated 03/12/24 for a fall that occurred at 01:18 PM, included an immediate intervention for staff to remind R20 to use his walker and they would assist him if they saw a safety concern. The 04/08/24 at 02:15 AM Progress Note revealed staff found R20 lying on his right side, on the floor, in front of his bathroom. R20 reported he fell and was not using his walker. The Risk Management Report dated 04/08/24 for fall that occurred at 02:15 AM, included an intervention stating R20 would be reminded to use his walker at all times and to let staff know if he needed anything. R20 had not fallen since this incident. The 06/05/24 at 11:40 PM Progress Note revealed staff found R20 seated in on the floor in a seated position against his bed. R20 reported he transferred himself out of bed and slid to the floor. The fall that occurred on 06/05/24 at 11:40 PM, lacked an intervention, an incident report, and lacked a Risk Management Report. The 06/19/24 at 12:30 AM Progress Note revealed staff entered R20s' room to answer his call light and found R20 seated on the floor with his back against the recliner. R20 reported he slid out of his chair and staff applied dycem (non-slip mat used for stabilization and gripping to prevent slipping) to the recliner. The Risk Management Report dated 06/19/24 for a fall that occurred at 12:30 AM, included an immediate intervention of dycem placed on the resident's recliner seat. The risk management report intervention included staff would continue to check on R20 every one to two hours to see if he needed to get up from his recliner. The 06/22/24 at 03:00 AM Progress Note revealed staff found R20 lying on his floor in front of his recliner. R20 reported he was walking, and he fell . The Risk Management Report dated 06/22/24 for fall that occurred at 03:00 AM, included an intervention that staff would remind R20 to call staff for assistance and staff will continue to make frequent checks on R20. The 08/01/24 at 03:55 AM Progress Note revealed staff found R20 seated on the floor in his room and in front of his bed, R20 slid off of the bed. The fall that occurred on 08/01/24 at 03:55 AM, lacked an intervention, an incident report, and lacked a Risk Management Report. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 08/06/24 at 04:00 AM Progress Note revealed staff found R20 lying on his left side on the floor beside his bed. R20 reported he rolled out of bed. The Risk Management Report dated 08/06/24 for fall that occurred at 04:00 AM, included an intervention for staff to continue to keep an eye on R20 during evening hours and when he is sleeping. Bed checks are to be completed every hour. If this continues to happen a discussion will occur with R20 about alternative ways to keep him safe while sleeping. The 08/28/24 at 03:00 AM Progress Note revealed staff found R20 on his floor tangled in blankets. R20 reported he did not know what happened. The fall that occurred on 08/28/24 at 03:00 AM, lacked an intervention and lacked a Risk Management Report. During an observation on 10/21/24 at 04:00 PM and 05:12 PM, R20 was seated in his lift chair in his room, the lift chair was approximately a quarter to halfway lifted and R20 was leaning towards the floor. No chair alarm was noted on recliner or in the resident's room. During an observation on 10/22/24 at 08:04 AM and 12:02 PM, R20 was seated in dining room in wheelchair, no alarm noted. No dycem or alarm observed on R20's recliner in his room. During an observation on 10/22/24 at 11:00 AM, R20 was seated in recliner watching his tv, no alarm noted. At 02:25 PM and 04:30 PM, R20 was seated in recliner in room with his feet elevated and his eyes closed. No alarm noted. During an interview on 10/23/24 at 08:26 AM, Certified Nurse Aide (CNA) M reported that R20 never had a personal alarm on his chair or any dycem noted on the seat of his recliner. During an interview on 10/23/24 at 09:14 AM, Licensed Nurse (LN) G reported Administrative Nurse D and Administrative Nurse E updated the care plans in the EHR. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D reported that Administrative Nurse E would update the care plan with the new intervention. Administrative Nurse D expected care plans to be updated within 24 hours. During an interview on 10/23/24 at 01:35 PM, Administrative Nurse D confirmed that R20's care plan lacked new interventions for all of the fall dates reviewed. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E expected a fall intervention to be completed on the care plan within 24 hours and confirmed that did not always occur. The facility policy LTC Fall Prevention Protocol dated 10/2020, documented each resident residing in this facility would be provided services and care that ensured all residents environments remain free from accident hazards as possible. The care plan will be reviewed and amended based on the re-assessments. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to update care plan with fall prevention interventions to prevent falls for cognitively impaired R20, who had a history of falls and several falls at facility. This deficient practice placed him at risk for further falls with injury. - The Electronic Health Records (EHR) documented R15 had the following diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The 02/28/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of two, indicating severely impaired cognition. R15 had a total mood severity score of one, indicating minimal depression and wandering behaviors one to three days of the observation period. R15 required moderate assistance with activities of daily living (ADL) such as showering and oral care. R15 was independent with bed mobility, transfers, and ambulation. R15 had no falls in lookback period. The 08/27/24 Falls Care Area Assessment (CAA) documented R15 did not have a fall while in facility and noted there was a potential for fall related to dementia and times of confusion. The 08/30/24 Quarterly MDS documented a BIMS score of three, indicating severely impaired cognition. R15 was independent with transfers and ambulation, she had one non-injury fall, and received antidepressant medications during the lookback period. The 10/21/24 Care Plan documented staff were instructed to provide stand by assist and use a gait belt at times if R15 was unsteady, date initiated 02/21/24. Staff were instructed to provide supervision with ambulation to monitor for safety, date initiated 06/14/24. The 10/21/24 Care Plan lacked any new intervention for fall on 08/23/24. The Progress Note on 08/23/24 at 08:15 AM, R15 had an unwitnessed fall when she lost her balance and fell , R15 reported that her shoe was falling off and caused her to fall. The Risk Management Report dated 08/23/24, lacked review and lacked an immediate intervention to prevent another fall. During an interview on 10/23/24 at 08:49 AM, Certified Nurse Aide (CNA) O reported the staff would discuss what intervention to implement to prevent another fall. The Nurse would communicate the intervention with the CNAs and it should be on the care plan or kardex in the EHR. During an interview on 10/23/24 at 09:14 AM, Licensed Nurse (LN) G reported Administrative Nurse D and Administrative Nurse E updated the care plans in the EHR. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D reported that Administrative Nurse E would update the care plan with the new intervention. Administrative Nurse D expected care plans to be updated within 24 hours. During an interview on 10/23/24 at 01:35 PM, Administrative Nurse D confirmed that R15's care plan lacked new interventions for all of the fall dates reviewed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E expected a fall intervention to be completed on the care plan within 24 hours and confirmed that did not always occur. The facility policy LTC Fall Prevention Protocol dated 10/2020, documented each resident residing in this facility would be provided services and care that ensured all residents environments remain free from accident hazards as possible. The care plan will be reviewed and amended based on the re-assessments. The facility failed to update care plan with fall prevention interventions to prevent falls for cognitively impaired R15, who had a history of falls. This deficient practice placed her at risk for further falls with injury. - The Electronic Health Records (EHR) documented R21 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), degenerative arthritis (a chronic condition that causes cartilage in the joints to break down over time) of bilateral (both sides) knees, and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). The 06/22/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R21 had a total mood severity score of four, indicating minimal depression and she had no behaviors. R21 required maximal assistance with activities of daily living (ADL) such as toileting hygiene, showering, personal hygiene, and dressing. R21 was independent with bed mobility, transfers, and ambulation. R21 had two non-injury falls and received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressants (class of medications used to treat mood disorders) medications during the lookback period. The 08/21/24 Falls Care Area Assessment (CAA) documented R21 was at risk for falls due to a history of falling and she was unsteady on her feet, mixed with her confusion at times. The 09/22/24 Quarterly MDS documented a BIMS score of three, which indicated severely impaired cognition. R21 required maximal assistance with bathing, toileting hygiene, and personal hygiene. R21 was independent with transfers and ambulation, and she had two non-injury falls and received antidepressant medications during lookback period. The 10/21/24 Care Plan documented the following fall prevention interventions, initiated 06/13/23: The staff were to encourage R21 to use call light for assistance, provide a safe environment with adequate low glare light, bed in the lowest position and wheels locked. R21 was able to use walker without assistance times at times R21 had an unsteady gait and staff instructed to provide stand by assist and gait belt as needed. The 02/10/24 at 10:21 AM Progress Note revealed staff found R21 on the floor, seated upright in front of her recliner. The note documented R21 reported she lost her balance and fell , and had no injuries noted. The 04/26/24 at 02:18 PM Progress Note revealed R21 continued to have bilateral knee pain and had more difficulty with ambulation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 04/27/24 at 02:31 AM Progress Note revealed staff found R21 on the floor in her bathroom. The note documented R21 had severe swelling noted on the right side of her face with lesions noted on her lower lip with severe bleeding. The note included R21 had bruising noted on the back of her right and left hands and both arms, and she transferred to the hospital. The 04/27/24 at 04:39 AM Progress Note revealed R21 returned from the hospital, and R21 had fractures of the sinus bones and a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to her right cheek. The Risk Management Report dated 02/10/24, included an immediate intervention to re-educated R21 to use the call light and to use the call light for assistance. The Risk Management Report dated 04/27/24, lacked an intervention to prevent another fall. The Care Plan included a fall prevention intervention dated 05/09/24 (12 days after R21's fall) instructed staff to provide stand by assistance for ambulation with her walker and gait belt, noting she may refuse at times for gait belt use. During an observation on 10/21/24 at 03:54 PM, R21 sat in her recliner with a seated rolling unlocked walker in front of her. She was very hard of hearing and had bilateral hearing aids in her ears. R21 had a hard time expressing her thoughts, as she stuttered and repeated her words. During an observation on 10/22/24 at 08:04 AM, R21 sat in her recliner with a seated rolling unlocked walker in front of her. On 10/23/24 at 08:20 AM, R21 ambulated independently to her room with a seated rolling walker from the dining room. The staff provided no assistance to R21 as she ambulated. During an interview on 10/23/24 at 08:49 AM, Certified Nurse Aide (CNA) O reported the staff would discuss what intervention to implement to prevent another fall. The Nurse would communicate with the CNAs and it should be on the care plan or kardex in the EHR. During an interview on 10/23/24 at 09:14 AM, Licensed Nurse (LN) G reported Administrative Nurse D and Administrative Nurse E updated the care plans in the EHR. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D reported that Administrative Nurse E would update the care plan with the new intervention. Administrative Nurse D expected care plans to be updated within 24 hours. During an interview on 10/23/24 at 01:35 PM, Administrative Nurse D confirmed that R20's care plan lacked new interventions for all of the fall dates reviewed. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E expected a fall intervention to be completed on the care plan within 24 hours and confirmed that did not always occur. (continued on next page)

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Kearny County Hospital Ltcu	607 Court Pl Lakin, KS 67860

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy LTC Fall Prevention Protocol dated 10/2020, documented each resident residing in this facility would be provided services and care that ensured all residents environments remain free from accident hazards as possible. The care plan will be reviewed and amended based on the re-assessments. The facility failed to update care plan with fall prevention interventions to prevent falls for cognitively impaired R21, who had a history of falls. This deficient practice placed her at risk for further falls with injury. 51332 - Review of the Electronic Health Records (EHR) for Resident (R)23 included the diagnoses of a stage 4 pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral region (large triangular bone/area between the two hip bones which included a deep pressure wound that reaches the muscles, ligaments, or even bone), primary osteoarthritis (a degenerative change to one or many joints characterized by swelling and pain), sacroiliitis (an inflammation of the sacroiliac joint [SI], usually resulting in pain), spinal stenosis (condition where the spinal canal, the passageway for the spinal cord, becomes narrowed, putting pressure on the spinal cord or nerve roots), bursitis (a common condition that causes pain in a joint), and insomnia (inability to sleep). The 06/10/24 Annual Minimum Data Set (MDS) documented R23 had a Brief Interview for Mental Status (BIM) score of 13, which indicated intact cognition. The MDS indicated R23 was dependent on staff for all care except eating and oral hygiene, which required set up/supervision. The resident utilized an indwelling catheter and was always continent of bladder and frequently incontinent of bowel. Review of the EHR on 10/22/24 lacked a Quarterly MDS that was due on 09/10/24 for R23 (28 days overdue). Review of the 09/19/24, Care Plan lacked documentation of interventions related to the inclusion of Enhanced Barrier Precautions (EBP) related to a chronic wound and urinary catheter care. The 08/26/24 at 08:09 PM Progress Note revealed R23 documentation of a stage 4 pressure ulcer to R23's sacral area noted to be healing well with a new dressing applied. Scant white colored drainage seen and wound without odor. The 08/17/24 at 08:15 PM Progress Note revealed R23 documentation of a stage 4 pressure ulcer to R23's sacral area to have the skin around the wound turned slightly red. Wound required to be cleansed, packed and dressing reapplied. The 07/26/24 at 01:52 PM Progress Note revealed R23 documentation of a stage 4 pressure ulcer to R23's coccyx area to minimal drainage as evidence on the old packing. The skin around the wound was observed to be pink and blanchable. Wound Care Center orders noted to be changed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 07/20/24 at 11:35 PM Progress Note revealed documentation of a wound care to R23's stage 4 pressure ulcer to R23's coccyx area. Dressing was removed due to being saturated during shower. Coccyx wound was measured at a length of 3-centimeter (cm) by a width of 3cm. Packing was observed to have green drainage on it with granulation present. Wound required to be cleansed, packed and dressing reapplied. It was noted that this was an improvement from previous measurement of a length of 2. 5-centimeter (cm) by a width of 1.8cm and depth of 3cm on 07/11/2024 at 06:55 PM. During an observation on 10/22/24 at 03:48 AM, R23 was having a wound dressing change performed by Licensed Nurse (LN) G, which required the assistance of Certified Nurse Aide (CNA) O and CNA N. During the dressing change, the only personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) worn by staff were gloves. Staff were unaware that EBP were infection control measures implemented to prevent the transmission of multidrug-resistant organisms (MDROs) required during wound care with R23. R23's wound measured at a length of 1.5-centimeter (cm) by a width of 0.5cm. The surveyor witnessed no hand hygiene during the dressing change. On 10/22/24 at 03:58 AM, CNA N stated catheter care was performed in the mornings when getting ready to start the day. CNA N noted staff would be aware if any residents were on precautions by a sign alerting them outside the resident's room door before they walked into the room. On 10/22/24 at 03:58 AM, CNA O stated staff performed catheter care in the mornings before the resident was out of bed and when they were visibly soiled. CNA O stated staff knew which type of precautions to use on residents in the facility by a sign posted outside of the resident's door and a cart of PPE supply located directly outside of that resident's room. CNA O stated that during rounds, each shift received a verbal report. During the interview, CNA O stated that the off-going CNA would tell the oncoming CNA if a resident went on precautions. On 10/22/24 at 04:36 PM, LN G stated catheter care was to be performed in the morning when a resident first got up for the day and whenever they were visually soiled. LN G stated precautions were posted outside of the resident's room and communicated during the nurse-to-nurse report. LN G stated the facility did not have any residents she was aware of who required special precautions. On 10/23/24 at 02:08 PM, Administrative Nurse D stated R23 was on EBP, and the staff was to be aware of this by the sign in the resident's bathroom, along with a cart of PPE supplies. Administrative Nurse D stated she expected staff to use the proper PPE when providing close-contained care such as dressing, toileting, transferring, wound care, and catheter care. During an interview on 10/23/24 at 04:00 PM Administrative Staff A and Administrative Nurse E, confirmed that there were several late MDS's submitted and completed late which included R23. Administrative Nurse E reported that when she took over the MDS position there were MDS's that were over a year late. Administrative Nurse E stated that there are residents that do not have their Quarterly MDS completed and confirmed that some are as late as a month. Administrative Nurse E stated she attempts to try to up care plans with new interventions after falls or change and it should be completed the next day. The facility failed to review and revise the person-centered comprehensive care plan for R23, including interventions related to the inclusion of EBP related to a chronic wound and urinary catheter care. These deficient practices had the potential for uncommunicated needs that could negatively impact R23's physical and psychosocial well-being. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51334 - Review of the 09/04/23 Annual Minimum Data Set (MDS) revealed R12 had no memory problems per staff interview. The MDS documented no falls since the previous assessment. Review of the Falls Care Area Assessment (CAA) dated 09/18/23, identified concerns of balance problems during transfers and the use of antianxiety and antidepressant medications. The CAA documented falls would be addressed in the care plan. Review of the 06/06/24 Quarterly Minimum Data Set revealed R12 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. R12 had two or more noninjury falls and one minor injury fall since the previous assessment. The 10/21/24 Care Plan lacked revision regarding new fall interventions for the falls for R12 on 01/09/24, 02/29/24, 03/09/24, 06/07/24, two falls on 07/03/24, 07/13/24, 08/14/24, 08/20/24, 09/09/24 and 10/19/24. (See F689) Observation on 10/22/24 at 01:41 PM, R12 was in her recliner with her call light within reach. Fall mat beside her bed. During an interview on 10/23/24 at 08:49 AM, Certified Nurse Aide (CNA) O reported when a resident fell , the staff on duty, CNAs and charge nurse would discuss what intervention to implement to prevent another fall. The nurse would communicate the new intervention with the CNAs, and it should be on the care plan in the EHR. During an interview on 10/23/24 at 09:14 AM, Licensed Nurse (LN) G revealed that after the fall, staff initiate an investigation and then hold a discussion with staff to come up with an immediate intervention for the rest of the shift, which would go on the care plan and was reported on to the next shift through end of shift report. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D reported the immediate intervention was completed by verbal communication, and Administrative Nurse E updated the care plan with the new intervention. Administrative Nurse D expected care plans to be updated within 24 hours. Administrative Nurse D reported R12's care plan lacked revisions regarding fall interventions. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E expected a fall intervention to be completed within 24 hours and confirmed care plan interventions were not revised for the falls listed above. The facility policy LTC Fall Prevention Protocol dated 10/2020, documented each resident residing in this facility would be provided services and care that ensured all residents environments remain free from accident hazards as possible. Every resident will be evaluated for casual factors after each fall. The care plan will be updated based on the assessment. The facility failed to revise the care plan with fall prevention interventions for cognitively impaired R12, who had repeated falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of the Electronic Health Record (EHR) revealed Resident (R)17 had the following diagnoses: pulmonary fibrosis (a process that causes lung scarring, in which fibrotic tissue blocks the movement of oxygen into the bloodstream. Low oxygen levels (and the stiff scar tissue itself) can cause shortness of breath), psychosis (any major mental disorder characterized by a gross impairment in reality perception), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), cognitive decline, osteoporosis (chronic arthritis without inflammation), bilateral osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) in the knees, and hearing loss. Review of the 04/20/24 Annual Minimum Data Set (MDS) revealed the resident had highly impaired hearing and moderately impaired vision. The MDS noted the Brief Interview for Mental Status (BIMS) score of 99, indicated the interview could not be completed. The staff interview for cognition revealed R17 rarely or never understood others but was understood per staff interview. The MDS documented the resident had memory problems. R17 knew the season, room location, and that she was in a nursing facility. The staff reported the resident had a total mood score of three, which indicated no depression. R17 was occasionally incontinent of bladder and was independent with transfers and toilet transfers. R17 required setup or touching assistance for transfers. The resident had an impairment to both arms. The resident received anticoagulant, diuretic and antidepressant medications and received oxygen. The MDS documented two or more noninjury falls since the previous assessment. Review of the Falls Care Area Assessment (CAA) dated 05/24/24, revealed R17 was at risk for falls due to a history of falls. Review of the 07/23/24 Quarterly Minimum Data Set revealed R17 had highly impaired hearing and moderately impaired vision. The Brief Interview for Mental Status (BIMS) of 99, the resident rarely or never understood others but was understood per staff interview. The MDS documented the resident had memory problems, knew she was in a nursing facility, but did not know the season, room location, or staff. The staff interview completed with a total mood score of 3, which indicated no depression. R17 used a walker and a wheelchair, was occasionally incontinent of bladder and bowel, required substantial to maximum assistance for toilet transfers, partial assistance for other transfers. The resident took diuretic and antidepressant medications and was on oxygen. The MDS documented R17 had two or more noninjury falls and one minor injury fall since the previous assessment. The 10/21/24 Care Plan documented the following fall interventions, initiated 05/10/23 assist with ambulation and transfers, utilizing therapy recommendations. The Care Plan provided no information on what the therapy recommendations were. This was updated on 10/11/24 to include as tolerated related to comfort care. The 10/21/24 Care Plan documented the following fall interventions: 07/07/23, bed in lowest position and keep the call light in reach. 07/21/23, use a walker. 06/22/24, use the sit-to-stand lift for transfers when resident was weak or having confusion. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan documented the following fall interventions; indicated a lack of new interventions related to falls on the following: 06/17/24 fall with no injury, 09/26/24 fall with minor injury and 09/30/24 fall with minor injury. Review of the Fall Risk Evaluation assessment (a fall risk assessment that predicts the likely hood of falls) completed on 01/07/24, 04/07/24, 06/27/24, 07/07/24 and 10/07/24 documented R17 had a high fall risk. Review of progress notes from 01/01/24 to 10/21/24 revealed two falls with no root cause analysis and no new care plan intervention to prevent further falls on the following days: Incident Note on 06/17/24 at 12:00 AM documented R17 had a fall with no injury. R17 was found on the floor with spilled water. The resident was confused and stated she got on the floor because her legs were weak, so she was scooted across the floor. Staff were unable to reorient the resident. They applied oxygen and her oxygen saturation increased to 90 percent (%). R17 had been confused and removing her oxygen according to the progress notes since 06/13/24. Health Status Note on 06/13/24 at 12:22 PM documented R17 was sent to the emergency room and returned for confusion and had an oxygen saturation of 73%. Started on an antibiotic and a steroid treatment. The Risk Management Report dated 06/17/24 for a fall that occurred at 12:00 AM, included an immediate intervention for frequent checks until a bed alarm could be placed. The Care Plan has no mention of an alarm for the resident. The Incident Note on 09/26/24 at 02:19 AM documented the bed alarm alerted staff to her room where the resident was seated on the floor with a 10 centimeter (cm) skin tear over a large bruise and staff applied a dressing. The resident stated she was reaching for something on her table. The Risk Management Report dated 09/26/24 for a fall that occurred at 02:00 AM for R17, included no immediate inte [TRUNCATED]

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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. 50659 The facility reported a census of 25 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to identify, implement, and reevaluate fall prevention interventions to prevent falls for six residents. Resident (R) 21 experienced a fall which resulted in multiple sinus fractures (broken bone) and R18's fall resulted in a hip fracture, which required hospitalization and surgery. Additionally, the facility failed to implement new interventions to prevent falls for R12, R17, R20 and R23, placing the residents at risk for falls with injury. Findings included: - The Electronic Health Records (EHR) documented R21 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), degenerative arthritis (a chronic condition that causes cartilage in the joints to break down over time) of bilateral (both sides) knees and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). The 06/22/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R21 had a total mood severity score of four, indicating minimal depression and she had no behaviors. R21 required maximal assistance with activities of daily living (ADL) such as toileting hygiene, showering, personal hygiene, and dressing. R21 was independent with bed mobility, transfers, and ambulation. R21 had two non-injury falls and received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressants (class of medications used to treat mood disorders) medications during the lookback period. The 08/21/24 Falls Care Area Assessment (CAA) documented R21 was at risk for falls due to a history of falling and she was unsteady on her feet, mixed with her confusion at times. The Psychotropic Drug Use CAA documented R21 requires several medications to control her mental health diagnosis. The 09/22/24 Quarterly MDS documented a BIMS score of three, indicating severely impaired cognition. R21 required maximal assistance with bathing, toileting hygiene and personal hygiene. R21 was independent with transfers and ambulation, and she had two non-injury falls. The 10/21/24 Care Plan documented the following fall prevention interventions, initiated 06/13/23: The staff were to encourage R21 to use call light for assistance, provide a safe environment with adequate low glare light, bed in the lowest position and wheels locked. R21 was able to use walker without assistance times at times R21 had an unsteady gait and staff instructed to provide stand by assist and gait belt as needed. The 10/21/24 Physician Orders lacked any documentation regarding falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Risk Evaluation for R21, documented the following: On 06/09/23 at 06:51PM, at risk for falls, score of 11.0. On 07/09/23 at 08:41 AM, at risk for falls, score of 11.0. On 08/09/23 at 09:19 AM, at risk for falls, score of 15.0. On 11/09/23 at 01:55 PM, no risk for falls, score of five. On 02/09/24 at 01:09 PM, at risk for falls, score of 12.0. On 02/10/24 at 02:36 PM, no risk for falls, score of nine. On 04/27/24 at 02:39 AM, at risk for falls, score of 21.0. On 08/09/24 at 12:53 PM, at risk for falls, score of 16.0. Per the facility's LTC Fall Prevention Protocol policy dated October 2020 a score of nine or greater represented the resident is at high risk for falls. The 02/10/24 at 10:21 AM Progress Note revealed staff found R21 on the floor, seated upright in front of her recliner. The note documented R21 reported she lost her balance and fell , and had no injuries noted. The 04/26/24 at 02:18 PM Progress Note revealed R21 continued to have bilateral knee pain and had more difficulty with ambulation. The 04/27/24 at 02:31 AM Progress Note revealed staff found R21 on the floor in her bathroom. The note documented R21 had severe swelling noted on the right side of her face with lesions noted on her lower lip with severe bleeding. The note included R21 had bruising noted on the back of her right and left hands and both arms, and she transferred to the hospital. The 04/27/24 at 04:39 AM Progress Note revealed R21 returned from the hospital, and R21 had fractures of the sinus bones and a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to her right cheek. The computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) scan, dated 04/27/24, revealed R21 had fractures of the anterior (front) and posterolateral (something is located on the side and toward the back of the body) walls of the right maxillary (a hollow, pyramid-shaped space in the cheekbones that's part of the paranasal sinus system [one of many small hollow spaces in the bones around the nose]) and nondisplaced (a broken bone in which the pieces of bone remain aligned and do not move out of place) fracture of the right orbital floor (forms the roof of the maxillary sinus). The Risk Management Report dated 02/10/24, included an immediate intervention to re-educated R21 to use the call light and to use the call light for assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Risk Management Report dated 04/27/24, lacked intervention to prevent another fall. The Care Plan included a fall prevention intervention dated 05/09/24 (12 days after R21's fall) instructing staff to provide stand by assistance for ambulation with her walker and gait belt, noting she may refuse at times for gait belt use. During an observation on 10/21/24 at 03:54 PM, R21 sat in her recliner with a seated rolling unlocked walker in front of her. She was very hard of hearing and had bilateral hearing aids in her ears. R21 had a hard time expressing her thoughts, as she stuttered and repeated her words. During an observation on 10/22/24 at 08:04 AM, R21 sat in her recliner with a seated rolling unlocked walker in front of her. On 10/23/24 at 08:20 AM, R21 ambulated independently to her room with a seated rolling walker from the dining room. The staff provided no assistance to R21 as she ambulated. During an interview on 10/23/24 at 08:49 AM, Certified Nurse Aide (CNA) O reported when a resident fell , the staff stay with the resident and call for assistance. The Nurse would assess the resident and complete paperwork. The staff would discuss what intervention to implement to prevent another fall. The Nurse would communicate with the CNAs and it should be on the care plan or kardex in the EHR. During an interview on 10/23/24 at 08:50 AM, CNA M reported R21 would ambulate independently with her walker in and out of her room all the time. During an interview on 10/23/24 at 09:14 AM, Licensed Nurse (LN) G reported an incident report was created (after a fall) in risk manager in the EHR after the assessment of a resident, notification of responsible party, physician, Administrative Staff A and Administrative Nurse D, witness statements from staff, and immediate intervention was completed. LN G stated they verbally communicated to let staff know and placed new interventions on the EHR white board. LN G stated Administrative Nurse D and Administrative Nurse E updated the care plans in the EHR. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D reported the immediate (fall prevention) intervention was completed by verbal communication, and Administrative Nurse E would update the care plan with the new intervention. Administrative Nurse D expected care plans to be updated within 24 hours. Administrative Nurse D reported R21's care plan lacked fall interventions. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E expected a fall intervention to be completed within 24 hours and confirmed that did not always occur. The facility policy LTC Fall Prevention Protocol dated 10/2020, documented each resident residing in this facility would be provided services and care that ensured all residents environments remain free from accident hazards as possible. The facility failed to implement effective fall prevention interventions to prevent falls for cognitively impaired 21, who had a history of falls. R21 fell at the facility and fractured her facial bones and the facility did not update the care plan with further fall prevention interventions until 12 days after her fall with major injury, placing her at risk for further falls with injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Resident (R) 20's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion) and parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The 12/23/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R20 had a total mood severity score of six, which indicated mild depression. R20 required set up assistance for eating and required moderate assistance with activities of daily living (ADLs) to include dressing, toileting hygiene, footwear, personal hygiene and standing. R20 required supervision for ambulation, oral care and transfers. R20 had two or more non-injury falls. The 06/22/24 Falls Care Area Assessment (CAA) documented R20 had a fall history and had falls while in facility. The 06/22/24 Cognitive Loss/Dementia CAA documented R20 required staff cues and assistance with ADL's and decisions for safety based on cognitive decline. The 06/26/24 Quarterly MDS documented a BIMS score of two, indicating severely impaired cognition. R20's total mood severity score of five, indicated mild depression. R20 required set up assistance for eating and required supervision assistance for oral care, transfers, and ambulation. R20 required maximal assistance with toileting hygiene, dressing, and standing. The resident had two or more non-injury falls and had a chair alarm. The 10/21/24 Care Plan documented the following fall prevention interventions, initiated 05/15/23: Staff were instructed to provide a safe environment with adequate low glare light, ensure the resident's bed was in the lowest position and ensure the wheels were locked on bed. The 10/21/24 Care Plan documented the following fall prevention interventions, initiated 03/15/24: Staff were instructed to determine and address causative factors of falls and follow facility post-fall policy regarding monitoring signs and symptoms of injury post fall. The 10/21/24 Care Plan lacked any documentation for the resident's chair alarm and any new fall interventions for the falls that occurred on 03/12/24 (two falls), 04/08/24, 06/05/24, 06/19/24, 06/22/24, 08/01/24, 08/06/24, and 08/28/24. The 10/21/24 Physician Orders lacked any documentation regarding falls or a chair alarm. The Fall Risk Evaluation for R21, documented the following: On 11/10/23 at 03:44 AM identified R21 as at risk for falls with a score of 16. On 02/09/24 at 07:59 PM identified R21 as at risk for falls with a score of 9. On 05/09/24 at 06:46 PM identified R21 as at risk for falls with a score of 14. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/09/24 at 08:01 PM identified R21 as at risk for falls with a score of 18. Per the facility's LTC Fall Prevention Protocol policy dated October 2020 a score of nine or greater represented the resident is at high risk for falls. The 03/12/24 at 02:24 AM Progress Note revealed staff found R20 on the floor leaning towards his left side, in front of his recliner. The lift chair was all the way up and his walker was approximately three feet away. R20 had socks on his feet and reported he slipped when he tried to get up to go to the bathroom. The fall that occurred on 03/12/24 at 02:24 AM, lacked an intervention and lacked a Risk Management Report. The 03/12/24 at 01:18 PM Progress Note revealed the resident had a witnessed fall, R20 ambulated independently in the dining room without his walker, bent over to pick up a cane on the floor, fell forward, and struck his head, which caused an abrasion to the top of his head. The Risk Management Report dated 03/12/24 for a fall that occurred at 01:18 PM, included an immediate intervention for staff to remind R20 to use his walker and they would assist him if they saw a safety concern. The 04/08/24 at 02:15 AM Progress Note revealed staff found R20 lying on his right side, on the floor, in front of his bathroom. R20 reported he fell and was not using his walker. The Risk Management Report dated 04/08/24 for fall that occurred at 02:15 AM, included an intervention stating R20 would be reminded to use his walker at all times and to let staff know if he needed anything. R20 had not fallen since this incident. The 06/05/24 at 11:40 PM Progress Note revealed staff found R20 seated in on the floor in a seated position against his bed. R20 reported he transferred himself out of bed and slid to the floor. The fall that occurred on 06/05/24 at 11:40 PM, lacked an intervention, an incident report, and lacked a Risk Management Report. The 06/19/24 at 12:30 AM Progress Note revealed staff entered R20s' room to answer his call light and found R20 seated on the floor with his back against the recliner. R20 reported he slid out of his chair and staff applied dycem (non-slip mat used for stabilization and gripping to prevent slipping) to the recliner. The Risk Management Report dated 06/19/24 for a fall that occurred at 12:30 AM, included an immediate intervention of dycem placed on the resident's recliner seat. The risk management report intervention included staff would continue to check on R20 every one to two hours to see if he needed to get up from his recliner. The 06/22/24 at 03:00 AM Progress Note revealed staff found R20 lying on his floor in front of his recliner. R20 reported he was walking, and he fell . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Risk Management Report dated 06/22/24 for fall that occurred at 03:00 AM, included an intervention that staff would remind R20 to call staff for assistance and staff will continue to make frequent checks on R20. The 08/01/24 at 03:55 AM Progress Note revealed staff found R20 seated on the floor in his room and in front of his bed, R20 slid off of the bed. The fall that occurred on 08/01/24 at 03:55 AM, lacked an intervention, an incident report, and lacked a Risk Management Report. The 08/06/24 at 04:00 AM Progress Note revealed staff found R20 lying on his left side on the floor beside his bed. R20 reported he rolled out of bed. The Risk Management Report dated 08/06/24 for fall that occurred at 04:00 AM, included an intervention for staff to continue to keep an eye on R20 during evening hours and when he is sleeping. Bed checks are to be completed every hour. If this continues to happen a discussion will occur with R20 about alternative ways to keep him safe while sleeping. The 08/28/24 at 03:00 AM Progress Note revealed staff found R20 on his floor tangled in blankets. R20 reported he did not know what happened. The fall that occurred on 08/28/24 at 03:00 AM, lacked an intervention and lacked a Risk Management Report. During an observation on 10/21/24 at 04:00 PM and 05:12 PM, R20 was seated in his lift chair in his room, the lift chair was approximately a quarter to halfway lifted and R20 was leaning towards the floor. No chair alarm was noted on recliner or in the resident's room. During an observation on 10/22/24 at 08:04 AM and 12:02 PM, R20 was seated in dining room in wheelchair, no alarm noted. No dycem or alarm observed on R20's recliner in his room. During an observation on 10/22/24 at 1 1:00 AM, R20 was seated in recliner watching his tv, no alarm noted. At 02:25 PM and 04:30 PM, R20 was seated in recliner in room with his feet elevated and his eyes closed. No alarm noted. During an observation on 10/23/24 at 07:43 AM, Certified Nurse Aide (CNA) M propelled R20 in his wheelchair with no foot pedals noted on wheelchair. R20 held his feet up and placed his feet on the floor one time. CNA M stopped pushing R20's wheelchair when she noticed the observation and asked R20 to take himself in his wheelchair and R20 refused. CNA M then pushed R20's wheelchair with his feet up into the dining room . During an interview on 10/23/24 at 07:45 AM, CNA M reported R20 normally would ambulate to the dining room with staff assistance, she reported R20 refused to ambulate this morning and that she would not normally push a wheelchair without foot pedals. During an interview on 10/23/24 at 07:50 AM, Licensed Nurse (LN) G reported that R20 should have foot pedals on his wheelchair when staff are pushing the wheelchair to prevent an incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 10/23/24 at 08:20 AM, R20 ambulated with CNA M to the TV lounge from the dining room, he used a front wheeled rolling walker and a gait belt was utilized. CNA M assisted R20 into a lift recliner in the TV lounge. During and interview on 10/23/24 at 08:26 AM, CNA M reported that R20 never had a personal alarm on his chair or any dycem noted on the seat of his recliner. CNA M reported R20 could use his left chair remote independently. During an interview on 10/23/24 at 09:14 AM, Licensed Nurse (LN) G reported an incident report was created (after a fall) in risk manager in the EHR after the assessment of a resident, notification of responsible party, physician, Administrative Staff A, and Administrative Nurse D, witness statements from staff, and immediate interventions were completed. LN G stated they verbally communicated to let staff know and placed new interventions on the EHR white board. LN G stated Administrative Nurse D and Administrative Nurse E updated the care plans in the EHR. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D reported the immediate (fall prevention) intervention was completed by verbal communication, and Administrative Nurse E would update the care plan with the new intervention. Administrative Nurse D expected care plans to be updated within 24 hours. During an interview on 10/23/24 at 01:35 PM, Administrative Nurse D confirmed that R20's care plan lacked new interventions for all of the fall dates reviewed and confirmed she did not have an incident report or investigation for the two falls. Administrative Nurse D confirmed the facility did not have a lift chair assessment and confirmed the TV lounge had lift chairs available for any resident to sit in. Administrative Nurse D had no comment when questioned about an intervention to remind a resident with severely impaired cognition to use a walker and if calling staff was an appropriate intervention to be used several times. During an interview on 10/23/24 at 04:00 PM, Administrative Nurse E expected a fall intervention to be completed within 24 hours and confirmed that did not always occur. The facility policy LTC Fall Prevention Protocol dated 10/2020, documented each resident residing in this facility would be provided services and care that ensured all residents environments remain free from accident hazards as possible. The care plan will be reviewed and amended based on the re-assessments. The facility failed to implement effective fall prevention interventions to prevent falls for cognitively impaired R20, who had a history of falls and several falls at facility. This deficient practice placed him at risk for further falls with injury. 46960 - Review of the Electronic Health Record (EHR) for Resident (R) 18 included diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion), epilepsy (a brain disorder characterized by repeated seizures), and frontotemporal neurocognitive disorder (a brain disease that affects behavior, language and movement abilities). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 04/22/24 Annual Minimum Data Set (MDS) completed 08/16/24, documented that the Brief Interview for Mental Status (BIMS) assessment could not be completed, and the staff assessed R18 to have severely impaired cognition. The assessment documented R18 displayed no behaviors and utilized a wheelchair for locomotion and was dependent on staff for all cares except oral hygiene which required substantial/maximum assistance and eating which required partial/moderate assistance. The assessment documented R18 had two or more falls since admission or the previous assessment which included one fall with major injury. The Delirium Care Area Assessment (CAA) dated 04/22/24, documented R18 had behaviors related to the diagnosis of dementia. The Cognitive Loss/Dementia CAA dated 04/22/24, documented R18 had decreased in cognition related to disease progression. The Communication CAA dated 04/22/24, documented R18 was unable to make her needs known. The Falls CAA dated 04/22/24, documented R18 was a high risk for falls related to seizure activity and behaviors. The 07/23/24 Quarterly MDS completed 08/16/24, documented the Brief Interview for Mental Status (BIMS) assessment could not be completed and the staff assessed R18 to have severely impaired cognition. The assessment documented R18 experienced hallucinations (sensing things while awake that appear to be real, but the mind created), displayed physical and verbal behavioral symptoms directed towards others one to three days during the seven-day look-back period. R18 utilized a walker and/or wheelchair for locomotion and was dependent on staff for all cares except eating which required partial/moderate assistance from staff. The assessment documented no falls since admission or the previous assessment. The 08/16/24 Care Plan documented on 04/23/23 that R18 could ambulate with stand-by assistance and gait (manner or style of walking) belt and staff should utilize a wheelchair for longer distances, initiated on 04/23/23 and revised on 04/12/24. The 08/16/24 Care Plan documented on 07/28/23 that R18 had an actual fall related to poor balance and poor communication/comprehension ability and included the following interventions: 07/28/23, staff should assist R18 to the bathroom every two hours and as needed, initiated on 07/28/23. 07/28/23, staff would place personal items within reach and gave examples of call light, water, and purse. Additionally, staff would answer call lights promptly. 07/28/23, staff would monitor for signs/symptoms of a medication reaction. 07/28/23, staff would provide activities that promote exercise and strength building where possible and provide one-on-one activities if R18 was bedbound. 07/28/23, revised 02/21/24, staff were instructed that R18 was able to ambulate with two-person assistance and gait belt use. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the EHR Fall Risk assessments revealed on 01/15/24, the facility documented a fall risk score of 13 which indicated R18 was at risk for falls. Review of the EHR Fall Risk assessments revealed on 04/15/24, the facility documented a fall risk score of 11 which indicated R18 was at risk for falls. Review of the EHR Fall Risk assessments revealed on 04/30/24, the facility documented a fall risk score of 14 which indicated R18 was at risk for falls. Review of the EHR Fall Risk assessments revealed on 07/15/24, the facility documented a fall risk score of 16 which indicated R18 was at risk for falls. Review of the EHR Fall Risk assessments revealed on 10/15/24, the facility documented a fall risk score of 14 which indicated R18 was at risk for falls. The Progress Notes dated 04/22/24 at 06:40 PM documented R18 experienced witnessed fall when she tripped and fell on her left side and was assessed to be free from observable injury. The Progress Notes dated 04/23/24 at 04:00 PM documented R18 was transferred to the Emergency Department (ED) per the recommendation of Administrative Nurse D and ED staff reported an x-ray report of a left femoral (thigh bone) neck fracture (broken bone) and R18 was transferred to another hospital for continued care. The Progress Notes dated 04/24/24 at 02:45 PM documented the facility staff called the hospital who stated that R18 was in surgery for a partial hip replacement. Review of the facility Fall Investigation revealed on 03/22/24 at 06:40 PM, R18 fell without injury. The facility's root cause analysis determined staff had failed to provide stand-by assistance and gait belt use,as indicated in the care plan which caused R18's fall. The fall investigation report lacked an immediate intervention to mitigate the fall risk for the remainder of the shift. The resident's Care Plan lacked an intervention related to the fall on 04/22/24. Review of the EHR Fall Risk assessments revealed on 04/22/24, the facility documented a fall risk score of 15 which indicated R18 was at risk for falls. The Progress Notes dated 06/15/24 documented R18 had a witnessed fall without injury when R18 was ambulating (walking) with staff and she had a seizure, and staff assisted R18 to the floor. The fall investigation report lacked an immediate intervention to mitigate the fall risk for the remainder of the shift. The resident's Care Plan lacked an intervention related to the fall on 06/15/24. Review of the EHR Fall Risk assessments revealed on 06/15/24, the facility documented a fall risk score of 14 which indicated R18 was at risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall investigation report, dated 07/25/24 at 06:15 PM lacked a root cause analysis or immediate intervention to mitigate the risk of falls for the remainder of the shift. The Progress Notes dated 07/27/24 at 03:09 PM documented R18 lacked injuries from a fall. The note lacked further documentation related to a fall. The Progress Notes dated 07/27/24 at 06:55 PM revealed a skin evaluation documented that R18 continued to have abrasions to her upper back after a fall. The resident's Care Plan lacked an intervention related to the fall on 07/25/24. During an observation on 10/21/24 at 03:40 PM and 10/22/24 at 12:48 PM, R18 rested in the recliner in her room, watching television. During an observation on 10/23/24 at 12:00 PM, R18 sat in her wheelchair in the dining area with staff providing eating assistance. During an interview on 10/23/24 at 08:49 AM, Certified Nurse Aide (CNA) O revealed that if she saw a fall or someone on the ground, she would ask them if they were okay then use the call light for assistance and/or yell for help and notify the nurse. After the resident was assessed and assisted off the ground, the nurse did paperwork and discussed what staff could do to prevent additional falls. The nurse would communicate an intervention to the staff and that intervention would be included in the end of shift report to the oncoming shift. CNA O stated she was not aware of a book at the nurses' station that had interventions in it. Further, CNA O stated there was a book, but it was not updated anymore, and staff could look in the Kardex for the interventions. During an interview on 10/23/24 at 08:23 AM, CNA P revealed if she saw a fall or someone on the ground, she would get the nurse or pull the call light for assistance to get the nurse. She stated she could not touch the resident until the nurse came. After the nurse arrived and assessed the resident, she would do what the nurse instructed, and she would assist the nurse to get the resident up. During an interview on 10/23/24 at 09:14 AM, Licensed Nurse (LN) G revealed that when she was notified of a fall, she would perform a full assessment on the resident and render aid if needed. After the fall, initiate an investigation which included collection of witness statements and notification of the Director of Nursing (DON), the resident's representative and the resident's physician. Then would hold a discussion with staff to come up with an immediate intervention for the rest of the shift, which would go on the care plan and was reported on to the next shift through end of shift report. During an interview on 10/23/24 at 11:03 AM, Administrative Nurse D revealed when there was a fall, she expected the CNA to notify the nurse and give details as to if it was witnessed or not witnessed. The nurse would perform a full assessment and render aid or send the resident to the ER if needed. The nurse would then document the fall in the EHR and come up with an immediate intervention that was communicated verbally to the staff. The nurse would then notify Administrative Nurse E so the permanent care plan could be updated. Administrative Nurse D expected the care plan to be updated within 24 hours and expected staff to review it individually the following day and again in the weekly risk meeting. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility policy LTC Fall Prevention Protocol dated 10/2020, documented each resident residing in the facility would be provided services and care that ensured all resident environments remain free from accident hazards as possible. The facility failed to implement fall prevention interventions after multiple falls for cognitively impaired and dependent R18, with a known history of repeated falls. R18 had an injury fall on 04/22/24, a non-injury fall on 06/15/24, and an injury fall on 07/25/24 with no fall prevention interventions identified and implemented to prevent further falls. This deficient practice resulted in actual injuries to R18 to the physical and psychosocial well-being of R18.

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F 0692 Level of Harm - Minimal harm or potential for 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** 50659 The facility reported a census of 25 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately assess the nutritional status of cognitively impaired Resident (R)124 on admission, placing the resident at risk for nutritional deficits. Findings included: - Resident (R) 124's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion) and depression. The 09/29/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of ten, indicating moderately impaired cognition. R124 had a total mood severity score of one, indicating none to minimal depression and she had one behavior noted she yelled at staff. R124 required set up for eating, had broken or loose fitting dentures, and was dependent on a wheelchair for mobility. The 09/29/24 Nutritional Status Care Area Assessment (CAA) for R124 documented staff did not have an issue with her nutrition. The 09/29/24 Dental Care CAA documented R124's bridges were broken related to the last injury fall with several broken teeth. The 10/21/24 Care Plan lacked interventions related to nutritional concerns. Review of the Physician Orders documented a regular diet, mechanical soft texture, and regular/thin consistency fluids related to dementia for R124, dated 09/16/24. On 10/21/24 review of the Assessments lacked any dietary profile in the EHR. Review of the Progress Notes from 09/16/24 through 10/21/24, lacked any progress notes from Consultant Staff GG. Additionally, they lacked any documentation for food preferences likes or dislikes. During an observation on 10/22/24 at 12:30 PM, R124 was seated in dining room eating lunch. R124 had a cup full of sliced cucumbers noted next to her salad. R124 stated, I don't like cucumbers, I really would like the chips that go with this taco salad, but they won't let me have them and that makes me sad because I can eat them. R124 had a frown on her face. R124 could not recall if she had spoken to any staff member about what she likes to eat. During an interview on 10/23/24 at 02:40 PM, Administrative Nurse D confirmed R124 had no dietary profile or Consultant/Registered Dietician Staff GG assessment or notes in EHR since admitted [DATE] to 10/21/24 and revealed that was a concern. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/24/24 at 09:28 AM, Consultant Dietician Staff GG confirmed that she had not seen R124 since she admitted on [DATE]. Consultant Staff GG reported she did not know R124 admitted to the facility on [DATE] and should have received that information from Dietary Staff BB. Additionally, she reported that was a concern as R124's preferences and nutritional needs were unknown, and Consultant Staff GG expected to have that completed within three days of admission. The facility lacked a policy for Registered Dietician visits. The facility failed to accurately assess a resident's nutritional status on admission R124. This placed the resident at risk for uncommunicated care needs and potential nutritional deficits.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 25 residents with 12 residents selected for review which included five residents reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards for four residents. The facility failed to ensure staff properly cleaned and stored the nebulizer (a device for administering inhaled medications) for Resident (R)12, R8, and R74. The facility failed to ensure R18's room remained free of used nebulizer equipment (from a prior discharged resident) not required for R18's medical care. Additionally, the facility failed to ensure the nasal cannula (a device to deliver low-concentration, low-pressure supplemental oxygen) were stored appropriately, sanitarily, when not in use for R12 and R8. These deficient practices had the potential to have a negative impact on the resident's physical well-being and at risk of respiratory infection. Findings included: - During an observation on [DATE] at 04:29 PM, R8 sat in her recliner and watched television. R8's oxygen cannula was coiled up and hung from the wall-mounted oxygen flowmeter (a device that regulates the flow of gas) and lacked a bag. R8's nebulizer sat intact on the bedside table with an unknown clear liquid in the atomizer chamber and lacked a date. During an observation on [DATE] at 04:41 PM, R74 sat in his recliner and watched television, an undated nebulizer sat intact on the bedside table and the atomizer chamber contained an unknown clear liquid. During an observation of R18's room on [DATE] at 12:12 PM, a nebulizer was attached to and stored on the wall-mounted oxygen flowmeter without a bag and the atomizer chamber contained an unknown clear substance. During an observation on [DATE] at 12:45 PM and at 04:38 PM, R8 sat in her recliner and watched television. R8's oxygen tubing was draped across the foot of the bed and the cannula rested on the bed. During an observation on [DATE] at 01:41 PM, R12 sat in her recliner and received oxygen via nasal cannula. R12's nebulizer was hung intact on a hook on the wall and the atomizer chamber contained an unknown clear liquid. During an observation of R12's room on [DATE] at 07:40 AM, 08:47 AM and 09:06 AM, R12's oxygen tubing draped over the over-the-bed table and the nasal cannula rested on the floor. During an observation of R18's room on [DATE] at 08:48 AM a nebulizer was attached to and stored on the wall-mounted oxygen flowmeter and the atomizer chamber contained an unknown clear substance. During an observation of R74's room on [DATE] at 08:49 AM an undated nebulizer sat intact on the bedside table and the atomizer chamber contained an unknown clear liquid. During an observation on [DATE] at 09:00 AM, R8 sat in her recliner and watched television. R8's oxygen tubing was draped across the foot of the bed and the cannula rested on the bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 09:08 AM, Certified Nurse Aide (CNA) P observed picking up R12's oxygen tubing that was draped on the over-the-bed table and the cannula rested on the floor and placed the cannula in R12's nose and failed to clean or replace the cannula. During an observation on [DATE] at 09:40 AM, Licensed Nurse (LN) G picked up the oxygen tubing draped over R8's bed and coiled the cannula up then hung the tubing over the wall-mounted flowmeter without a bag or without cleaning. During an interview on [DATE] at 09:55 AM, LN G reported the nurses handle the breathing treatments and are responsible for the nebulizers, which should be dated and rinsed out after every treatment and set to dry on a paper towel to dry until the next treatment. LN G stated no nebulizers should be left intact between treatments as this was an infection control concern. LN G confirmed that R18 did not have any diagnoses that would require the use of nebulized medications and that R18 did not receive nebulized medications. LN G stated that the previous occupant of R18's room did receive nebulized medications, but that resident had expired in December of 2023 (10 months prior). During an interview on [DATE] at 10:35 AM, Administrative Nurse D revealed she expected staff to rinse out the nebulizers after every treatment and then set them on a paper towel to dry before the next treatment. Administrative Nurse D said oxygen tubing, when not in use, should be coiled up and hanging in a bag on a hook on the wall, rather than hanging from flow meter or draped over furniture, as it was an infection control concern. Administrative Nurse D said nebulizers found intact with unknown clear liquid in the atomizer chamber was an infection control concern and should be discarded and replaced with new equipment and dated. Administrative Nurse D said all oxygen equipment and tubing should be replaced at least once per month, and as needed if contaminated or suspected to be contaminated. The facility failed to provide a policy related to respiratory care on [DATE] and Administrative Nurse D stated the facility lacked a policy related to respiratory care. The facility failed to properly clean and store the nebulizer for R12, R8 and R74; failed to ensure R18's room remained free of used nebulizer equipment not required for R18's medical care; and failed to ensure that the nasal cannulas were stored appropriately when not in use for R12 and R8. These deficient practices had the potential to have a negative impact on the residents' physical well-being and at risk for respiratory infection.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 25 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to ensure the Physician documented and conducted the in person admission visit as required for Resident (R)124. Findings included: - Resident (R)124's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion) and depression. The 09/29/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of ten, indicating moderately impaired cognition. R124 had a total mood severity score of one, indicating none to minimal depression and she had one behavior noted she yelled at staff. R124 required set up for eating and was dependent on a wheelchair mobility. R124 had impairment noted to one upper and lower side of her body. The 09/29/24 Admission MDS for R124 had no date for completion of the MDS, the CAA or submission record as of 10/21/24. Review of the EHR revealed R124 admitted to the facility on [DATE] and lacked a Physician visit note uploaded as of 10/21/24. Review of the Progress Notes from 09/16/24 through 10/21/24, lacked any progress notes of a physician visit. During an interview on 10/24/24 at 10:18 AM, Administrative Nurse D confirmed R124 had not been seen by a physician since admitted on [DATE] and reported that was a concern. Review of the Initial Provider Visit dated 10/26/24, documented R124 was seen by provider. Provider note was received on 10/28/24 from Administrative Nurse D. The provider assessed R124, 41 days after admission. The facility lacked a policy on Physician Visits. The facility failed to ensure the Physician visits were conducted in person and documented as required for R124 for admission. This placed the resident at risk for uncommunicated care needs.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 51334 The facility had a census of 25 residents. Based on observation, record review, and interview, the facility failed to provide Registered Nurse (RN) coverage eight hours a day, seven days a week, placing all residents who reside at the facility at risk of lack of assessments and inappropriate care. Findings included: - Upon review of Payroll Based Journal (PBJ- a required detail information submitted by nursing homes of staffing information that is required by the Centers of Medicare and Medicaid Services [CMS]) the facility reported a lack of consecutive eight-hour RN coverage for 39 days from July 1, 2023, through June 30, 2024. Review of the Fiscal Year FY Quarter 4 2023 (July 1 - September 30, 2023), the following days lacked an RN for consecutive eight-hour coverage: 08/16/23, 08/17/23, 08/22/23, 09/04/23, 09/09/23, 09/10/23, 09/23/23 and 09/24/23. Review of the FY Quarter 1 2024 (October 1 - December 31, 2023), the following days lacked an RN for consecutive eight-hour coverage: 10/07/23, 10/21/23,11/04/23, 11/18/23, 11/19/23, 11/23/23, 12/02/23, 12/03/23, 12/16/23, 12/26/23 and 12/30/23. Review of the FY Quarter 2 2024 (January 1 - March 31, 2024), the following days lacked an RN for consecutive eight-hour coverage: 01/01/24, 01/13/24, 01/14/24, 01/27/24, 02/04/24, 03/10/24, 03/23/24, 03/24/24 and 03/31/24. Review of the FY Quarter 3 2024 (April 1 - June 30, 2024), the following days lacked an RN for consecutive eight-hour coverage: 04/07/24, 04/11/24, 04/16/24, 04/30/24, 05/04/24, 5/05/24, 05/19/24, 06/01/24, 06/02/24, 06/29/24 and 06/30/24. Upon review of the facility's schedule for Licensed Nurses of the months of July 2023, August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, May 2024, and June 2024 39 dates lacked consecutive eight-hour RN coverage. On 10/23/24 at 04:30 PM, Administrative Staff A stated she was aware there was no consecutive eight-hour RN coverage on the days listed above. Some of the days had partial RN coverage due to the 12-hour shifts running from 05:00 AM to 05:00 PM and 05:00 PM to 05:00 AM. The facility failed to provide a policy related to staffing coverage as requested on 10/23/24. Administrative Nurse D stated that the facility lacked a policy related to staffing coverage. The facility failed to provide Registered Nurse coverage eight consecutive hours a day, seven days per week, placing the residents who resided in the facility at risk of lack of assessment and inappropriate care.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 51332 The facility reported a census of 25 residents. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included the daily census and nursing hours, as required Findings included: - During observation on 10/23/24 at 03:40 PM, daily staffing sheets hung on the back wall of the nurse's station. The nurse staffing sheet form lacked the total number or actual hours worked by licensed and unlicensed staff along with the daily resident census. Review of the Daily Schedule Nursing Hours sheets from 09/24/24 through 10/23/24, revealed the information sheets lacked the total number or actual hours worked by licensed and unlicensed staff along with the daily resident census. On 10/24/24 at 11:41 AM, Administrative Staff A and Administrative Nurse D reported they were not aware of a federal requirement to have daily staffing sheets completed containing the required elements. The facility did not provide a policy for posting nurse staffing information. The facility failed to ensure the posted daily nurse staffing sheets included the daily census and nursing hours, as required.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 51332 The facility identified a census of 25 residents. The sample included 12 residents with the residents reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care services. Based on observation, record review, and interviews, the facility failed to support Residents (R)19 and R124 and implement care planned interventions to address dementia care needs. This deficient practice placed the residents at risk for impaired ability to achieve and/or maintain their highest practicable level of functioning and wellbeing. The facility failed to implement individualized interventions, as well as revise the care plan accordingly, to address individualized interventions related to the residents symptomology and rate of progression as evidenced by observation, record review, and/or interview. Findings included: - Review of Resident (R) 19's Electronic Health Record (EHR) included diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), insomnia (inability to sleep), Alzheimer's disease, (progressive mental disorder characterized by failing memory, confusion), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), urinary tract infection (UTI - an infection in any part of the urinary system) and hypertension (elevated blood pressure). The 10/14/23 Annual Minimum Data Set (MDS) documented R19 was unable to complete the Brief Interview of Mental Status (BIMS) and staff assessed R19 to have severely impaired cognition. R19 had no signs of depression and no behaviors documented. The assessment documented that R19 utilized a walker and required moderate assistance with bathing and personal hygiene, supervision assistance with toileting and dressing and was independent with eating and oral care. The assessment failed to document R19 received any antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression), anticoagulant (a class of medication used to prevent blood from clotting) and diuretic (a class of medication to promote the formation and excretion of urine) in the seven-day look-back period. The 10/14/23 Care Area Assessment (CAA) triggered in the following areas but lacked further development/documentation for Cognitive Loss/Dementia, the following CAAs did not trigger for further review/development: Psychosocial Well-Being, Behavioral Symptoms, and Psychotropic Medication Use. The 07/16/24 Quarterly MDS documented the resident had a BIMS score of six, which indicated severely impaired cognition. R19 required supervision assistance with walking and utilized a walker. R19 required maximal assistance with bathing and partial/moderate assistance with all other cares. R19 received antidepressant, anticoagulant, and diuretic during the seven-day look-back period. The 09/04/24 Care Plan located in the EHR documented R19 utilized an antidepressant medication and included the following interventions: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/02/23, staff would monitor and report adverse reactions to medication therapy, changes in behavior/mood/cognition, hallucinations (sensing things while awake that appear to be real, but the mind created)/delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), changes in R19's ability to perform ADLs. 05/02/23, Staff would administer medications as ordered and monitor and document any side effects and effectiveness every shift. The 09/04/24 Care Plan lacked documentation of individualized interventions and measurable outcomes or monitoring of effectiveness of interventions regarding R19's Alzheimer's diagnosis. During an observation on 10/23/24 at 09:50 AM, R19 sat in a recliner in the activity room and watched television alone. The staff let R19 know they would be in and out to check on her and if she needed anything to let them know when she saw them next. During an interview on 10/23/24 at 09:51 AM Certified Nursing Assistant (CNA) Q stated the resident did not have any behaviors and she was quiet. CNA Q stated when a resident did have a behavior that the CNA observes the CNA would notify tells the nurse and the nurse would instruct the CNAs what intervention to implement/utilize. Additionally, the nurse was the one who would document the behavior. Further, stated the reason residents were in the television room is because there is almost always staff there to watch them, so they have constant supervision. On 10/23/24 at 10:25 AM, CNA M stated R19 did not have history of Alzheimer's or behaviors and she was alert. CNA M stated R19 has made false statements against staff by stating staff had not asked her something when they had. CNA M said the resident refused food so staff would leave the plate with the resident and offer an alternative option to eat. CNA M Further stated that staff preferred to utilize cares in pairs to ensure another staff member in the room as a witness. On 10/23/24 at 10:39 AM, Licensed Nurse (LN) G stated resident is normally corporative though had been isolative and occasionally would pout but had never been inappropriate with staff. LN G stated interventions were decided by staff who knew the residents and the effectiveness of the interventions that were documented in the progress notes on the hot rack. LN G was unaware what cares in pairs was in reference to or how it was used with R19. LN G stated she was unaware of R19's diagnosis of Alzheimer's disease. On 10/23/24 at 02:37 PM, Administrative Nurse D stated R19 had a behavior of raising her lift chair when needing to go to the bathroom and waited for staff to notice and prompt her to go to the bathroom. Stated that CNAs would mark their documentations in the EHR, and nurses would document their interventions in the progress notes. Administrative Nurse D had to look up R19's medical diagnosis to confirm diagnosis of Alzheimer's replying and stated that she could not tell she had Alzheimer's or dementia by talking with R19. The facilities Behavior Management in Dementia Care dated approved 02/2022 stated all behaviors related to any/all types of dementia are to be monitored and documented. Documentation requires to include the intervention preformed, if the intervention was effective or ineffective and lastly that non-pharmacological interventions attempted prior to medication administered. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure that R19 was provided individualized care approaches and failed to provide documentation of non-pharmacological interventions attempted. The facility failed to implement individualized interventions, as well as revise the care plan accordingly, to address individualized interventions related to the residents symptomology and rate of progression. The facility did not provide documentation of interventions preformed or the care plan being reviews or revied with individualized goals and interventions to attain or maintain the resident's highest practicable well-being. This deficient practice placed the residents at risk for impaired ability to achieve and/or maintain their highest practicable level of functioning and wellbeing. 50659 - Resident (R) 124's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion), and depression. The 09/29/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of ten, indicating moderately impaired cognition. R124 had a total mood severity score of one, indicating none to minimal depression and she had one behavior noted she yelled at staff. R124 required set up for eating and was dependent on a wheelchair mobility. R124 received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressant (class of medications used to treat mood disorders) medications. The 09/29/24 Behavioral Symptoms Care Area Assessment (CAA) documented R124 suffered from hallucinations related to dementia. Staff would re-orient her and she became angry and verbal with staff. The 09/29/24 Psychotropic Drug Use CAA documented R124 takes medications as prescribed. The 10/17/24 Care Plan lacked documentation of individualized interventions and measurable goals regarding R124's behaviors. Additionally, the care plan lacked R124 was administered antipsychotic and antidepressant medications. The 10/17/24 Care Plan R124 had impaired cognition and dementia, staff instructed to administer medications as ordered and monitor for side effects and effectiveness, date initiated 09/17/24. The Physician Orders documented Sertraline HCl (is an antidepressant medication used to manage and treat the major depressive disorder) 25 milligram tablets, give two tablets by mouth, one time a day for depression dated ordered 09/16/24. Seroquel (antipsychotic medication used for the treatment of schizophrenia [mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought], bipolar disorder [major mental illness that caused people to have episodes of severe high and low moods] and major depressive disorder) give 25 milligram tablet, one tablet by mouth, at bedtime for auditory hallucinations, date ordered 10/09/24. The Progress Note on 10/14/24 at 03:33 AM, R124 refused to go to bed, and stated staff are doing things to her, but could not specify what things. R124 would become easily agitated with staff and yell at them. R124 had episodes of confusion and verbal aggression. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note on 10/15/24 at 09:36 PM, R124 agitated and hostile with staff after staff answers her call light, R124 would be hateful to staff and that she did not belong there. Staff attempted to re-orient R124, then R124 called staff stupid. R124 was not easily re-directed. The Progress Note on 10/16/24 at 08:45 PM, R124 very agitated with staff that she does not know why she is here and if she broke into somebody's home. During an observation on 10/21/24 at 04:54 PM, R124 was in her room seated in her recliner. A personal alarm was noted, R124 reported that when she stood up it reminded her to sit back down. During an observation on 10/22/24 at 10:30 AM, R124 was in the beauty shop, smiling and laughing with beautician. During an interview on 10/22/24 at 02:30 PM, Licensed Nurse (LN) G reported R124 was confused ad could get upset at times, LN G reported R124 is a new admit and confirmed that R124's care plan lacked behavioral interventions. During an interview on 10/23/24 at 08:30 AM, Certified Nurse Aide (CNA) O reported R124 was confused, and staff should attempt to re-orient resident as needed. During an interview on 10/23/24 at 10:39 AM, LN G stated interventions were decided by staff who knew the residents and the effectiveness of the interventions that were documented in the progress notes on the facility reporting system. During an interview on 10/23/24 at 02:37 PM, Administrative Nurse D reported CNAs would mark their behavior documentations in the EHR, and nurses would document their interventions in the progress notes. The facilities Behavior Management in Dementia Care dated approved 02/2022 stated all behaviors related to any/all types of dementia are to be monitored and documented. Documentation requires to include the intervention preformed, if the intervention was effective or ineffective and lastly that non-pharmacological interventions attempted prior to medication administered. The facility failed to ensure R124 was provided individualized care approaches and failed to provide documentation of non-pharmacological interventions attempted. The facility failed to implement individualized interventions to address individualized interventions related to the resident's symptomology and rate of progression. This deficient practice placed the residents at risk for impaired ability to achieve and/or maintain their highest practicable level of functioning and wellbeing.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46960 The facility reported a census of 25 residents. The sample included 12 residents with six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to act upon the pharmacist's monthly medication review (MRR) on 06/30/24 for Resident (R)18. The deficient practice had the potential to lead to the residents receiving unnecessary mediations. - Review of the Electronic Health Record (EHR) for Resident (R)18 included diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion), epilepsy (a brain disorder characterized by repeated seizures), frontotemporal neurocognitive disorder (a brain disease that affects behavior, language and movement abilities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The 04/22/24 Annual Minimum Data Set (MDS) completed 08/16/24, documented that the Brief Interview for Mental Status (BIMS) assessment could not be completed, and the staff assessed R18 to have severely impaired cognition. The assessment documented R18 displayed no behaviors and utilized a wheelchair for locomotion and was dependent on staff for all cares except oral hygiene which required substantial/maximum assistance and eating which required partial/moderate assistance. The assessment documented R18 received an antidepressant (a class of medications used to treat mood disorders) medication and opioid (a class of medications used to treat severe pain) medication. The Delirium Care Area Assessment (CAA) dated 04/22/24, documented R18 had behaviors related to the diagnosis of dementia. The Cognitive Loss/Dementia CAA dated 04/22/24, documented R18 had decreased in cognition related to disease progression. The Communication CAA dated 04/22/24, documented R18 was unable to make her needs known. The Falls CAA dated 04/22/24, documented R18 was a high risk for falls related to seizure activity and behaviors. The Psychotropic Drug Use CAA dated 04/22/24, documented R18 remained on medications due to behavioral symptoms. The 07/23/24 Quarterly MDS completed 08/16/24, documented the Brief Interview for Mental Status (BIMS) assessment could not be completed and the staff assessed R18 to have severely impaired cognition. The assessment documented R18 experienced hallucinations (sensing things while awake that appear to be real, but the mind created), displayed physical and verbal behavioral symptoms directed towards others one to three days during the seven-day look-back period. R18 utilized a walker and/or wheelchair for locomotion and was dependent on staff for all cares except eating which required partial/moderate assistance from staff. The assessment documented R18 received an antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) medication, an antidepressant medication, and an opioid medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 08/16/24 Care Plan documented on 04/23/23 that R18 used antidepressant and included the following interventions: 04/23/23, consulting pharmacist and physician would review medication regimen to utilize the lowest possible effective dose. The 08/16/24 Care Plan documented on 04/23/23 that R18 had impaired cognitive function and/or impaired thought processes related to dementia and included the following interventions: 04/23/23, administer medications as ordered and monitor/document for side effects and effectiveness. 04/23/23, staff would notify the nurse of negative behaviors that persisted after non-pharmacological (without the use of medications) interventions. Review of the EHR Physician's Orders documented the following: Sertraline (an antidepressant) HCl 150 milligrams (mg), give 150mg orally (PO), once daily in the morning related to depression, dated 04/04/23. Hydrocodone-acetaminophen (an opioid) 5-325mg, give one tablet PO every eight hours as needed for left hip pain, dated 04/29/24. The EHR lacked documentation related to non-pharmacological interventions attempted by staff. The Progress Notes dated 06/30/24 at 07:16 PM, Consultant Pharmacist HH documented the monthly medication regimen review (MRR) was completed and a gradual dose reduction (GDR) was created and diagnosis review. The progress note lacked description of what medication was targeted by the GDR. The facility failed to produce the facility's or physician's response. During an observation on 10/21/24 at 03:40 PM and 10/22/24 at 12:48 PM, R18 rested in the recliner in her room, watching television and appeared calm and relaxed. During an interview on 10/23/24 at 09:51 AM, Certified Nursing Assistant (CNA) Q stated when a resident did have a behavior that the CNA observes the CNA would notify tells the nurse and the nurse would instruct the CNAs what intervention to implement/utilize. Additionally, the nurse was the one who would document the behavior. During an interview on 10/23/24 at 10:39 AM, Licensed Nurse (LN) G stated interventions were decided by staff who knew the residents and the effectiveness of the interventions that were documented in the progress notes on the hot rack but failed to elaborate on what the hot rack was. During an interview on 10/23/24 at 02:37 PM, Administrative Nurse D confirmed the missing MRR/GDR report from 06/30/24 and the lack of documentation related to non-pharmacological interventions attempted by staff. Administrative Nurse D stated that Consultant Pharmacist HH was responsible for the creation of the MRR/GDR documents and that Consultant Pharmacist HH failed to provide the facility with a copy of the reports. Additionally stated that Consultant Pharmacist HH is no longer under contract with the facility due to lack of communication with the facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facilities Monitoring Antipsychotic Medications and Unnecessary Medications dated 10/2024 defined an unnecessary medication as any antipsychotic medication that was used without adequate monitoring. Additionally documented that non-pharmacologic interventions would be attempted prior to and during administration of antipsychotic medication (and could be divided further into five main categories: antipsychotics [class of medications used to treat psychosis and other mental emotional conditions], antidepressants, anti-anxiety [class of medications that calm and relax people with excessive anxiety, nervousness, or tension], stimulants [any medication or substance that produces a temporary increase in the functional activity of the nervous system], and mood stabilizers[a class of medications used to treat a specific mental disorder]). Specific behaviors must be seen and documented for these medications to be used such as the resident who was a danger to self or others or behaviors that interfered with staff's ability to provide care; or elder experiencing frightful distress due to paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), hallucinations (sensing things while awake that appear to be real, but the mind created), or delusions (an untrue persistent belief or perception held by a person although evidence shows it was untrue). The facility failed to ensure that R18 was free of unnecessary psychotropic medications and failed to provide documentation of non-pharmacological interventions attempted, further the facility did not provide documentation of the required MRR and attempted GDR of an unknown medication. This deficient practice had the potential to lead to R18 receiving unnecessary.

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Kearny County Hospital Ltcu	607 Court Pl Lakin, KS 67860

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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** 46960 The facility reported a census of 25 residents. The sample included 12 residents with six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure Resident (R)74's medication regimen remained free of as needed (PRN) psychotropic (any class of medications that alters mood or thought) medication that lacked the required 14 day stop date or clinical rationale for continued use beyond the initial 14 days. This deficient practice had the potential to lead to the resident receiving unnecessary psychotropic medications. Findings Included: - R74's Electronic Health Record (EHR) revealed diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure) The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The assessment documented R74 utilized a walker and/or a wheelchair for locomotion. The resident received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders). The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/15/24 documented R74 had periods of confusion. The Psychotropic Drug Use CAA dated 10/15/24 documented R74 had no prescribed antidepressant medication. The Physician Orders revealed an order for Ativan (lorazepam, a benzodiazepine class of medication which works on the neurotransmitters in the brain and is used to treat anxiety) 0.5 milligram (mg), give 0.5 mg every eight hours PRN for anxiety, dated 10/01/24. The order lacked a stop date or rationale for the continued use of the medication. Review of the Census tab on the EHR revealed that R74 admitted to the facility on [DATE]. Review of the electronic Medication Administration Record (eMAR) from 10/01/24 to 10/23/24 revealed R74 had not received any doses of PRN Ativan (lorazepam) and lacked evidence of an ordered stop date. During an observation on 10/21/24 at 04:41 PM, R74 sat in his recliner, watching television and appeared relaxed and calm. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/24 at 12:14 PM, R74 sat in his wheelchair at a table in the dining area with peers present and appeared relaxed and calm. During an interview on 10/23/24 at 11:22 AM, Administrative Nurse D confirmed the order for PRN Ativan (lorazepam) in R74's EHR lacked a stop date. Administrative Nurse D stated she was unaware of the regulatory requirement that PRN psychotropic medications required a 14 day stop date or documented an appropriate clinical rationale for continued use beyond the 14 days. The facility's Psychotropic Monitoring and Unnecessary Medications policy, dated 10/2024 documented that residents residing in the facility would remain free of unnecessary medications and defined an unnecessary medication as one with an excessive duration and lacked instructions to include a 14 day stop date or an appropriate clinical rationale for continued use beyond the 14 days. The facility's undated Medication Administration and Monitoring policy documented that the facility's interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) would review the use of PRN orders for psychotropic medications to determine the appropriateness and effectiveness to minimize use and that it performed this review monthly through the Quality Assurance Performance Improvement (QAPI) process. The facility failed to ensure a 14-day stop date or physician rationale for continued use beyond the 14 days, for R74's PRN psychotropic medication, Ativan. This deficient practice had the potential for R74 to receive an unnecessary psychotropic medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46960 The facility census totaled 25 residents on two halls and had two medication carts. Based on observation, interview, and record review, the facility failed to ensure the staff and 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, containing oral, topical and inhaled medications. This deficient practice placed nine cognitively impaired, independently mobile residents at risk. Findings included: - On 10/22/24/24 at 07:38 AM, observation revealed an unlocked and unattended medication cart that contained oral, topical and inhaled medications in the hall between the dining area and commons area. During an interview on 10/22/24 at 07:38 AM, Certified Medication Aide (CMA) S identified the cart as her responsibility and stated the cart should be locked when not attended. CMA S stated the (medication cart) lock would not engage if the drawers were not fully closed, even if the lock appeared engaged. CMA S stated that maintenance had recently replaced the lock. CMA S stated the cart in question serviced 22 residents and did not contain controlled substances. CMA S identified that the facility had two medication carts. During an interview on 10/22/24 at 08:00 AM, Licensed Nurse (LN) G stated whoever holds the keys for the medication cart was responsible for the cart and ensuring the drawers were fully closed and the lock was fully engaged, before walking away. During an interview on 10/22/24 at 08:09 AM, Administrative Nurse D stated she expected staff to ensure the drawers were fully closed and the lock was fully engaged before walking away. Administrative Nurse D confirmed that maintenance had recently replaced the lock on the medication cart and stated that since the problem had persisted, the facility should procure a new medication cart. Administrative Nurse D identified nine residents as confused and independently mobile. The facility's HPRV Medication Storage policy, dated 10/2024, documented medication carts would be locked by the CMA or LN when not in use. 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 hallway.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 25 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to accommodate a resident's preferences related to dietary preferences for one Resident (R)124. Findings included: - Resident (R) 124's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion) and depression. The 09/29/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of ten, indicating moderately impaired cognition. R124 had a total mood severity score of one, indicating none to minimal depression and she had one behavior noted she yelled at staff. R124 required set up for eating and was dependent on a wheelchair mobility. R124 had impairment noted to one upper and lower side of her body. The 09/29/24 Nutritional Status Care Area Assessment (CAA) R124 did not have an issue with her nutrition. The 10/21/24 Care Plan lacked documentation for the type of diet with consistency and/or R124's food preferences. Review of the EHR revealed R124 admitted to the facility on [DATE]. Review of the Physician Orders documented a regular diet, mechanical soft texture, and regular/thin consistency fluids related to dementia for R124, dated 09/16/24. On 10/21/24 review of the Assessments lacked any dietary profile in the EHR. Review of the Progress Notes from 09/16/24 through 10/21/24, lacked any progress notes from Consultant Staff GG. Additionally, they lacked any documentation for food preferences likes or dislikes. During an observation on 10/22/24 at 12:30 PM, R124 was seated in dining room eating lunch. R124 had a cup full of sliced cucumbers noted next to her salad. R124 stated, I don't like cucumbers, I really would like the chips that go with this taco salad, but they won't let me have them and that makes me sad because I can eat them. R124 had a frown on her face. R124 could not recall if she had spoken to any staff member about what she likes to eat. During an interview on 10/23/24 at 02:40 PM, Administrative Nurse D confirmed R124 had no dietary profile or Consultant/Registered Dietician Staff GG assessment or notes in EHR since admitted [DATE] to 10/21/24 and revealed that was a concern. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/24/24 at 09:28 AM, Consultant Staff GG confirmed that she had not seen R124 since she admitted on [DATE]. Consultant Staff GG reported she did not know R124 admitted to the facility on [DATE] and should have received that information from Dietary Staff BB. Additionally, she reported that was a concern as R124's preferences and nutritional needs were unknown, and Consultant Staff GG expected to have that completed within three days of admission. The facility's policy Resident Rights dated 03/2024, documented each resident residing in this facility will be afforded the rights to a dignified existence, self-determination, as well as communication with and access to persons and services inside and outside the facility without interference or reprisal. Each resident will have autonomy and choice about how they wish to live their life and receive care. The facility failed to assess the dietary preferences of R124 in order to provide foods to meet the resident's preferences.

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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. 51332 The facility reported a census of 25 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility. Findings included: On 10/21/24 at 02:37 PM during an initial tour of the main kitchen and refrigerator storage areas with Dietary Staff BB, the following areas of concern were observed: One unsealed/uncovered tray fruit-gelatin dessert located in the refrigerator. One uncovered, extra-large, metal steam container full of sandwich baggies, which contained unidentifiable food and lacked a date or label located in the freezer. One unsealed bag of hotdogs, without a date or label and located in the freezer. One unsealed bag of pepperoni, without a date or label and located in the freezer. One unsealed bag of frozen fish patties, without a date or label and located in the freezer. One sealed container of bulk breadcrumbs without a date or label. Seven sealed plastic containers of cereal with a use by date of 05/29/24, no opened date documented and located in main kitchen. Twenty cutting boards with uncleanable surfaces showing discoloration along with deep slices that were visible. During an observation on 10/21/24 at 02:37 PM the refrigerator labeled 2R had a temperature of 42 degrees Fahrenheit (F). Further observation on 10/21/24 revealed temperature logs on unit refrigerators and freezers were not maintained and temperatures documented were out of range of the facility stated policy. Review of Food Storage Refrigerator Temperature log sheets revealed the following documentation: Refrigerators were to be maintained between 33 and 36 degrees Fahrenheit, and freezers maintained between -0 to -10 degrees Fahrenheit. There was notation documented on the sheet that R corresponded with refrigerator and F corresponded with freezer. 09/10/24 through 10/22/24 the refrigerator labeled 1R was documented 43 times as out-of-range. 09/10/24 through 10/22/24 the refrigerator labeled 2R was documented 53 times as out-of-range. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	09/10/24 through 10/22/24 the refrigerator labeled 3R was documented 64 times as out-of-range. 09/10/24 through 10/22/24 the refrigerator labeled 4R was documented 38 times as out-of-range. 09/10/24 through 10/22/24 the refrigerator labeled 5R was documented 40 times as out-of-range. 09/10/24 through 10/22/24 the freezer labeled 6F was documented 32 times as out-of-range. 09/10/24 through 10/22/24 the refrigerator labeled WR1 was documented 58 times as out-of-range. 09/10/24 through 10/22/24 the freezer labeled WR1 was documented 35 times as out-of-range. The freezer lacked temperatures logged for 10/1/24 through 10/22/24 on the morning log sheet. 09/10/24 through 10/22/24 the refrigerator labeled CC was documented 60 times as out-of-range. 09/10/24 through 10/22/24 the freezer labeled CC was documented 32 times as out-of-range. The freezer lacked temperatures logged for 10/1/24 through 10/22/24 on the morning log sheet. On 10/21/24 at 02:57 PM, an interview with Dietary Manager BB revealed she expected staff to label and date opened food items. Dietary Manager BB stated that the above concerns identified with kitchen and freezer storage, which included undated and unsealed items were unacceptable. Dietary Manager BB revealed that once food was put into the freezer it was good for 6 months and that was why the expiration date was to be documented on the label. On 10/22/24 at 11:45 AM, an interview with Dietary Staff CC revealed every shift was required to document the refrigerator and freezer temperatures, which started on 09/10/24 when the written logs were made. Before the written logs each refrigerator and freezer had their own thermometer that would remotely take temperatures every 15 minutes then it would upload it to the facility software. Staff would be notified when the temperature was off by an alarm sounding from that refrigerator or freezer. On 10/24/24 at 09:48 AM, an interview with Dietary Manager BB reveled she expected all staff to complete the temperature logs and notify her if any refrigerators or freezers were out of range. Once staff notified her of out-of-range temperatures she was able to fix it promptly as she previously had in the past. On 10/24/24 at 10:18 AM, an interview with Dietary Staff BB reveled the paper refrigerator logs provided were all the records of refrigerator temps that existed. Dietary Staff BB stated that the facility recently changed how it recorded refrigerator temperatures. The facility's policy Food Storage dated 07/2019 reveled that all foods are to be covered, labeled, and dated. Facility policy stated stock was required to be rotated and used in the order of first in - first out method allowing staff ensure food consumed by ready-to-eat date. Temperatures for the refrigerators are to be between 35-39 degrees and freezer are to be 0 degrees or below Fahrenheit. Temperatures are to be monitored always by a cloud-based thermometer. When temperatures are out-of-range, an alarm is sent to the Directors phone, Productions phone and Purchasing phone. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 51332 The facility reported a census of 25 residents. Based on observation, interview, and record review, the facility failed to maintain and/or dispose of garbage and refuse properly, and in a sanitary condition, ensuring the lids were down to cover the disposed waste and prevent the potential harboring/feeding of pests. Findings included: - Initial tour of the outside trash dumpsters on 10/21/24 at 02:37 PM with Dietary Manager BB, revealed two out of the seven dumpsters had the lids in the open position. On 10/21/24 at 02:37 PM, Dietary Manager BB, revealed she was not aware of the requirement to have trash covered. On 10/23/24 at 10:48 AM, Administrative Nurse D, stated she was unaware that dumpsters fell under dietary responsibility and believed the city was responsible for the conditions, repairs, and maintenance the dumpsters required. The facility's policy Waste Disposal dated 09/2019 revealed that all waste would be kept covered unless in production and any leaks, creaks or dents in the trash can or to the lid would be reported to the production manager. The facility failed to provide sanitary garbage and refuse containers that were maintained with lids closed or otherwise covered. This deficient practice had the potential to lead to the harborage and feeding of pests.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46960 50659 The facility reported a census of 25 residents. Based on observation, interview, and record review the facility failed to provide administrative services in a manner to effectively and efficiently use resources to attain/maintain each resident's highest physical, mental, and psychosocial well-being, for all 25 residents that resided in the facility. Findings included: The facility failed to provide Resident (R) 17 care in a dignified manner when it referred to the table where the resident was placed as a feeder table in the electronic charting. This deficient practice placed the resident at risk for decreased psychosocial well-being. (See F550). The facility failed to ensure R124, R20, R21, R15, and R74 had accurate advanced directives completed. This deficient practice had the potential to lead to uncommunicated needs regarding the resident's choice in end-of-life care. (See F578). The facility failed to promote a clean homelike environment for five residents R2, R8, R23, R74 and R124. These deficient practices had the potential to spread possible infections to the residents in the facility and had the potential to lead to negative psychosocial effects related to non-home-like environment. (See F584). The facility failed to provide written notification of facility-initiated discharges/transfers to the resident or resident's representative, or the LTCO. This placed the residents at risk of uninformed care choices. (See F623). The facility failed to provide written notification of the facility's bed hold policy to the resident or resident's representative with facility-initiated discharges/transfers. This placed the residents at risk of an impaired ability to return to the facility and to the previous room for R18, R12 and R23. (See F625). The facility failed to accurately complete the CAAs for R8, R12, R17, R18, R74 and R124 related to several CAAs triggered. This placed the residents at risk for uncommunicated care needs. (See F636). The facility failed to complete a Quarterly Minimum Data Set (MDS) assessment in a timely manner for eight residents, R8, R10, R12, R17, R18, R19, R20, and R21. This placed the residents at risk for unmet care needs and inaccurate assessments. (See F638). The facility failed to complete a comprehensive MDS assessment in a timely manner for ten residents. Resident (R)8, R10, R12, R15, R17, R18, R19, R20, R21 and R124. This placed the residents at risk for unmet care needs and inaccurate assessments. (See F640). (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to accurately complete the MDS for R8, R20, and R12 related to falls. This placed the residents at risk for uncommunicated care needs. (See F641). The facility failed to complete a baseline care plan for R74 and R124. This deficient practice had the potential to lead to uncommunicated needs. (See F655). The facility failed to develop and implement a person-centered comprehensive care plan for R74 related to psychotropic medication, diuretic medication, or nebulized medication use. This deficient practice had the potential to lead to uncommunicated needs which had the potential to negatively affect the physical and psychosocial well-being of R74. (See F656). The facility identified a census of 25 residents, which included 12 residents sampled. Based on interviews, observations, and record review, the facility failed to review and revise the care plans with appropriate interventions for eight of the sampled residents; R23 related to treatment of an area of pressure ulcer/injury and enhanced barrier precautions (EBP - a set of infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact cares) related to wound care and urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care; R19, R15, R20, R21, R17, R12 and R18 related to development and implementation of appropriate interventions to prevent multiple falls. These deficient practices resulted in uncommunicated care needs. (See F657). The facility reported a census of 25 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to identify, implement, and reevaluate fall prevention interventions to prevent falls for six residents. Resident (R) 21 experienced a fall which resulted in multiple sinus fractures (broken bone) and R18's fall resulted in a hip fracture, which required hospitalization and surgery. Additionally, the facility failed to implement new interventions to prevent falls for R12, R17, R20 and R23, placing the residents at risk for falls with injury. (See F689). The facility failed to accurately assess a resident's nutritional status on admission R124. This placed the resident at risk for uncommunicated care needs and potential nutritional deficits. (See F692). The facility failed to properly clean and store the nebulizer for R12, R8 and R74; failed to ensure R18's room remained free of used nebulizer equipment not required for R18's medical care; and failed to ensure that the nasal cannulas were stored appropriately when not in use for R12 and R8. These deficient practices had the potential to have a negative impact on the residents' physical well-being and at risk for respiratory infection. (See F695). The facility failed to ensure the Physician visits were conducted in person and documented as required for R124 for admission. This placed the resident at risk for uncommunicated care needs. (See F714). (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to provide Registered Nurse coverage eight consecutive hours a day, seven days per week, placing the residents who resided in the facility at risk of lack of assessment and inappropriate care. (See F727). The facility failed to ensure the posted daily nurse staffing sheets included the daily census and nursing hours, as required. (See F732). The facility identified a census of 25 residents. The sample included 12 residents with the residents reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care services. Based on observation, record review, and interviews, the facility failed to support Residents (R)19 and R124 and implement care planned interventions to address dementia care needs. This deficient practice placed the residents at risk for impaired ability to achieve and/or maintain their highest practicable level of functioning and wellbeing. The facility failed to implement individualized interventions, as well as revise the care plan accordingly, to address individualized interventions related to the resident's symptomology and rate of progression as evidenced by observation, record review, and/or interview. (See F744). The facility reported a census of 25 residents. The sample included 12 residents with six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to act upon the pharmacist's monthly medication review (MRR) on 06/30/24 for Resident (R)18 and R19. The deficient practice had the potential to lead to the residents receiving unnecessary mediations. (See F756). The facility failed to ensure a 14-day stop date or physician rationale for continued use beyond the 14 days, for R74's PRN psychotropic medication, Ativan. This deficient practice had the potential for R74 to receive an unnecessary psychotropic medication. (See F758). 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 hallway. (See F761). The facility failed to assess the dietary preferences of R124 in order to provide foods to meet the resident's preferences. (See F806). The facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility. (See F812). The facility failed to provide sanitary garbage and refuse containers that were maintained with lids closed or otherwise covered. This deficient practice had the potential to lead to the harborage and feeding of pests. (See F814). The facility failed to accurately complete a PBJ report for four quarters. Which placed all residents who reside at the facility at risk of lack of assessments and inappropriate care. (See F851). (continued on next page)

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	17E531	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kearny County Hospital Ltcu	607 Court Pl Lakin, KS 67860

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to conduct at least one performance improvement project, annually. This deficient practice has the potential to affect all 25 residents of the facility. (See F867). The facility failed transport clean linens in a method to protect clean linens from dust or soiling when staff left the clean linen cart uncovered during transport. The facility further failed to maintain an effective infection control program related to the maintaining an annually reviewed Infection Prevention and Control Program. The facility failed to provide respiratory care consistent with professional standards of care for R8, R18 and R74 regarding the use and cleaning of the nebulizer equipment and R12 oxygen supplies were not stored in a clean manner. The facility staff failed to utilize enhanced barrier precautions when providing catheter care and wound care on R23. These deficient practices had the potential to spread possible infections to the residents in the facility. (See F880). The facility failed to provide ongoing antibiotic stewardship to ensure appropriate antibiotic use for the residents of the facility to prevent antibiotic resistance and the spread of multi drug resistant organisms. (See F881). The facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. This failure has the potential to affect all 25 residents. (See F882). The facility failed to provide proof of declination or proof of immunization of the pneumococcal vaccine for these five residents and failed to receive the witness signature for the influenza vaccine for two residents. (See F883). The facility failed to ensure four of the five Certified Nurse Aides (CNA) sampled lacked the required 12 hours per year in-service training. (See F947). The facility failed to provide administrative services in a manner to effectively and efficiently use resources to attain/maintain each resident's highest physical, mental, and psychosocial well-being, for all 25 residents that resided in the facility.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50659 The facility had a census of 25 residents. Based on observation, record review, and interview, the facility failed to accurately complete a Payroll Based Journal (PBJ- a required detail information submitted by nursing homes of staffing information that is required by the Centers of Medicare and Medicaid Services [CMS]) reports for Registered Nurse (RN) coverage eight hours a day, seven days a week and failed to accurately complete a PBJ report for Licensed Nursing Coverage 24 hours/day. Which placed all residents who reside at the facility at risk of lack of assessments and inappropriate care. Findings included: - Review of the Fiscal Year FY Quarter 4 2023 (July 1 - September 30), the following days lacked an RN for consecutive eight-hour coverage: 08/16/23 (WE), 08/17/23 (TH), 08/22/23 (TU), 09/04/23 (MO), 09/09/23 (SA), 09/10/23 (SU), 09/23/23 (SA) and 09/24/23 (SU). Review of the FY Quarter 1 2024 (October 1 - December 31), the following days lacked an RN for consecutive eight-hour coverage: 10/07/23 (SA), 10/21/23 (SA),11/04/23 (SA), 11/18/23 (SA), 11/19/23 (SU), 11/23/23 (TH), 12/02/23 (SA), 12/03/23 (SU), 12/16/23 (SA), 12/26/23 (TU) and 12/30/23 (SA). Additionally, the following days lacked Licensed Nurse 24 hour coverage: 11/04 (SA); 11/08 (WE); 11/23 (TH); 11/24 (FR). Review of the FY Quarter 2 2024 (January 1 - March 31), the following days lacked an RN for consecutive eight-hour coverage: 01/01/24 (MO), 01/13/24 (SA), 01/14/24 (SU), 01/27/24 (SA), 02/04/24 (SU), 03/10/24 (SU), 03/23/24 (SA), 03/24/24 (SU) and 03/31/24 (SU). Review of the FY Quarter 3 2024 (April 1 - June 30), the following days lacked an RN for consecutive eight-hour coverage: 04/07/24 (SU), 04/11/24 (TH), 04/16/24 (TU), 04/30/24 (TU), 05/04/24 (SA), 05/05/24 (SU), 05/19/24 (SU), 06/01/24 (SA), 06/02/24 (SU), 06/29/24 (SA) and 06/30/24 (SU). Upon review of the facility's schedule for Licensed Nurses of the months of July 2023, August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, May 2024, and June 2024 a total of 39 dates lacked RN consecutive eight-hour coverage. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/23/24 at 04:30 PM, Administrative Staff A reported she was aware that there was no consecutive eight- hour RN coverage on the days listed above. Some of the days had partial RN coverage due to the 12-hour shifts running from 05:00 AM to 05:00 PM and 05:00PM to 05:00 AM. The facility failed to provide a policy on PBJ reporting. The facility failed to accurately complete a PBJ report for four quarters. Which placed all residents who reside at the facility at risk of lack of assessments and inappropriate care.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 50659 The facility reported a census of 25 residents. Based on observation, interview, and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) program (a management process for long-term care (LTC) facilities that ensures care practices are consistently applied and quality standards are met) conducted at least one performance improvement project annually, that focused on high-risk or problem prone areas, identified by the facility, through data collection and analysis. This failure has the potential to affect all 25 residents. Findings included: - On 10/24/24 at 12:03 PM, Administrative Nurse D reported the required members do meet at least quarterly for the facility's Quality Assurance Performance Improvement (QAPI) program. Administrative Nurse D reported that no annual performance improvement project had been conducted for the facility and she stated, It is a work in progress. The facility's policy Quality Assurance and Performance Improvement dated 08/2024, documented the facility strives, on continuous basis, to respond to identified needs of the communities in our service and to improve those systems and processes that support the delivery of high quality patient services. The facility failed to conduct at least one performance improvement project, annually. This deficient practice has the potential to affect all 25 residents of the facility.

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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. 50659 The facility reported a census of 25 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed transport clean linens in a method to protect clean linens from dust or soiling when staff left the clean linen cart uncovered during transport. The facility further failed to maintain an effective infection control program related to the maintaining an annually reviewed Infection Prevention and Control Program (IPCP) (a practical, evidence-based approach preventing patients and health workers from being harmed by avoidable infections). The facility staff failed to utilize enhanced barrier precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes) (EBP) when providing catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care and wound care on Resident (R) 23. The facility failed to provide respiratory care consistent with professional standards of care for R8, R18 and R74 regarding the use and cleaning of the nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) equipment and R12 oxygen supplies were not stored in a clean manner. This deficient practice had the potential to spread possible infections to the residents in the facility. Findings included: Observation on 10/21/24 at 12:12 PM, R18 had an intact nebulizer hanging from wall-mounted flow meter. Observation on 10/21/24 at 02:50 PM, R12 had oxygen tubing draped over wheelchair and not dated. Observation on 10/21/24 at 03:30 PM, R23 no Enhanced Barrier Precautions signage, or equipment noted for R23 in room or outside of room. R23 had a foley catheter and an open pressure ulcer. Observation on 10/21/24 at 04:25 PM, R8 had an intact nebulizer on bedside table, no date noted. Additionally, clear liquid noted in chamber. Observation on 10/21/24 at 04:41 PM, R74 had an intact nebulizer on bedside table, no date noted. Additionally, clear liquid noted in chamber. Observation on 10/22/24 at 12:45 PM, R8 had an intact nebulizer on bedside table, no date noted. Additionally, clear liquid noted in chamber. Observation on 10/22/24 at 12:14 PM, R74 had an intact nebulizer on bedside table, no date noted. Additionally, clear liquid noted in chamber. Observation on 10/22/24 at 03:48 PM, R23 received wound care by Licensed Nurse (LN) G, no personal protective equipment (PPE - equipment worn to protect against physical, chemical, and biological hazards) was worn by LN G. Certified Nurse Aide (CNA) N and CNA O also assisted LN G with wound care and provided peri-care and neither CNA donned PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/22/24 at 04:00 PM, CNA O reported if a resident was on any precautions, a sign would be hung on the resident's door outside, and a cart with ppe to be worn by staff would be outside the resident's door. Interview on 10/22/24 at 04:15 PM, CNA N reported if a resident was on any precautions, a sign would be hung on the resident's door outside, and a cart with ppe to be worn by staff would be outside the resident's door. She also confirmed there was no sign in R23's bathroom and the cart in R23's bathroom that contained gowns was not for EBP it was for his personal belongings and brief's. Interview on 10/22/24 at 04:22 PM, Certified Medication Aide (CMA) S reported if a resident was on precautions a sign would be posted outside a resident's door. CMA S reported if a resident has a wound or a catheter the staff should wear PPE when providing care. Interview on 10/22/24 at 04:36 PM, LN G reported that R23 was not on any precautions, and she would not have done anything differently when performing wound care. Observation on 10/23/24 at 07:40 AM, R12's oxygen tubing draped over bedside table with nasal canula on the floor. Observation on 10/23/24 at 08:48 AM, R18 had an intact nebulizer hanging from wall-mounted flow meter. Interview on 10/23/24 at 09:55 AM, Licensed Nurse (LN) G reported that nebulizer equipment should be dated and rinsed out and air dried after each use. Interview on 10/23/24 at 10:35 AM, Administrative Nurse D expected staff to rinse out the nebulizers and place the equipment on a towel to air dry after each use. Administrative Nurse D revealed that the oxygen tubing should be stored in a bag and placed on a hook when not in use. Additionally, she reported all oxygen/respiratory equipment should be dated and replaced once a month or as needed. Administrative Nurse D reported she did not know why R18 had a nebulizer in her room. Interview on 10/23/24 at 02:08 PM, Administrative Nurse D reported staff would know that any resident was on EBP as a sign is posted in the residents' bathroom with PPE stored in bathroom for staff to use. EBP should be sed at all times when providing wound care or catheter care. Observation on 10/24/24 at 08:33 AM, four unidentified laundry staff members delivered personal linens to the residents' rooms in the 200 hallway. The cover was not replaced over the clean personal linen that remained in the cart when the laundry staff walked away from the linen cart. Observation on 10/24/24 at 08:35 AM, Laundry Staff U reported that the linen cart should have been covered after removing the linen that was to be delivered. Interview on 10/24/24 at 08:54 AM, Laundry Director V reported the uncovered linen in the hallway was an concern. Interview on 10/24/24 at 10:20 AM, Administrative Nurse D reported that the linen should be covered in the hallway when being delivered, she also reported the facility's policy Infection Prevention Plan had not been reviewed annually. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy Infection Prevention Plan dated 05/2021, documented infection prevention is an important consideration in every decision and plan. Infection prevention must be integral responsibility of all personnel. It required cooperation between all departments. It is the responsibility of administration to oversee and provide resources for the Infection Prevention Program. The facility lacked a policy on care of respiratory equipment. The facility lacked a policy on EBP. The facility's policy Storage of Laundry Supplies dated 05/2024, documented all linens will be stored, handled, transported and processed in a manner that prevents the transmission of microorganisms (an organism that can be seen only through a microscope. Microorganisms include bacteria, protozoa, algae, and fungi) to other patients and areas. Clean linens shall be transported to patient care areas by use of covered carts with solid bottoms by laundry staff. The facility failed transport clean linens in a method to protect clean linens from dust or soiling when staff left the clean linen cart uncovered during transport. The facility further failed to maintain an effective infection control program related to the maintaining an annually reviewed Infection Prevention and Control Program. The facility failed to provide respiratory care consistent with professional standards of care for R8, R18 and R74 regarding the use and cleaning of the nebulizer equipment and R12 oxygen supplies were not stored in a clean manner. The facility staff failed to utilize enhanced barrier precautions when providing catheter care and wound care on R23. These deficient practices had the potential to spread possible infections to the residents in the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 50659 The facility reported a census of 25 residents. Based on interview and record review the facility failed to ensure staff adhered to the principles of antibiotic stewardship through monitoring for the appropriate use of antibiotics prescribed for residents to prevent antibiotic resistance and spread of multidrug resistant organisms within the facility. Findings included: - Interview, on 10/24/24 at 10:20 AM, with Administrative Nurse D reported that a resident who received an order for an antibiotic would have finished the medication before she had time to evaluate the antibiotic, labs, and residents' Electronic Health Record (EHR). Administrative Nurse D reported that the hospitals EHR does not communicate with the facilities' EHR and that would make it difficult to assure appropriate use of antibiotics. She reported the provider would give and order for an antibiotic prior to receiving the culture and sensitivity report back and the resident would not be on the correct antibiotic when report was received as it was not a susceptible antibiotic. Additionally, the provider is not updated on the incorrect antibiotic as the resident had finished the course of the original antibiotic order. Administrative Nurse D revealed that the charge nurse would open the Infection Prevent Report on EHR and not complete or answer the questions correctly. The facility's policy Antimicrobial Stewardship for Long Term Care dated 05/2021, documented the facility was committed to combat bacterial resistance and minimize adverse effects related to treatment with antimicrobial (a substance that kills or prevents the growth of microorganisms, such as bacteria, viruses, fungi, or mold) medications. It is a coordinated program of interventions that are designed to improve and measure appropriate use of antimicrobials. The facility failed to provide ongoing antibiotic stewardship to ensure appropriate antibiotic use for the residents of the facility to prevent antibiotic resistance and the spread of multi drug resistant organisms.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 50659 The facility reported a census of 25 residents. Based on interview and record review the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program (IPCP). This failure has the potential to affect all 25 residents. Findings included: - During an interview on 10/22/24 at 09:15 AM, Administrative Staff A revealed the facility did not employ a qualified IP. Administrative Staff A reported the IP in the hospital would answer questions for Administrative Nurse D and Administrative Nurse E when needed. Administrative Staff A reported that neither Administrative Nurse D nor Administrative Nurse E have completed an Infection Prevention and Control Program (IPCP). During an interview on 10/24/24 at 10:20 AM, Administrative Nurse D confirmed she had not started a IPCP at this time. The facility's policy Infection Prevention Plan dated 05/2021, documented the designated IP would be responsible for the day-to-day functions of facility infection prevention program. The IP's duties include: Developing a system for identifying, investigating, reporting, and preventing the spread of infections. The facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. This failure has the potential to affect all 25 residents.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 50659 The facility reported a census of 25 residents with 12 residents sampled. Based on interview and record review the facility failed to provide the pneumococcal vaccine (vaccine designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) consent/declination form to five residents reviewed. (Resident (R) 8,12,18,19 and 124). Additionally, the facility failed to provide a second witness signature on R12 and 18's influenza vaccine (a vaccine designed to prevent influenza [highly contagious viral infection]) consent forms. Findings included: - Review of the Electronic Health Record (EHR) of 2023-2024 for R8, R12 and R19 lacked documentation of the pneumococcal vaccine declination form. Additionally, their EHR lacked documentation of the historical pneumococcal vaccine immunization record. R18 and 124 lacked any documentation for consent/declination of pneumococcal vaccine. Review of the EHR of 2024 - 2025 for R8,12,18,19 and 124 lacked required documentation of influenza vaccine. During an interview on 10/24/24 at 10:15 AM, Administrative Nurse D confirmed that R8,12 and 19 had historical pneumococcal vaccine documentation in EHR, but lacked the actual declination form and immunization record that the pneumococcal vaccine was administered in the past. Administrative Nurse D confirmed EHR lacked documentation for R18 and 124's pneumococcal vaccine Review of influenza vaccine on 10/24/24 03:00 PM for R12 and 18 lacked a second witness signature for consent to administer influenza vaccine. During an interview on 10/24/24 at 03:00 PM, Administrative Nurse E confirmed the influenza vaccine consent form should contain a witness signature that a verbal consent was received. The facility's undated policy Influenza and Pneumococcal Vaccines documented influenza and pneumococcal disease have a major impact on high mortality on residents. Vaccines are highly effective in reducing health care costs and preventing illnesses, hospitalization s and death. All residents will be screened at admission to determine if they are current on influenza and pneumococcal immunization and status shall be documented in the EHR. Residents with undocumented pneumococcal vaccine shall be offered the vaccine. Influenza vaccine shall be offered during the months of September through March to all residents. The facility failed to provide proof of declination or proof of immunization of the pneumococcal vaccine for these five residents and failed to receive the witness signature for the influenza vaccine for two residents.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46960 The facility reported a census of 25 residents. Based on interview and record review, the facility failed to ensure four of the five Certified Nurse Aides (CNA) sampled lacked the required 12 hours per year in-service training. This placed the residents at risk for decreased quality of life and/or inadequate care. Findings included: - On 10/24/24 at 10:00 AM, review of training records for five CNAs employed by the facility for more than one year revealed four CNAs had less than 12 hours of documented in-service training for the previous 12 months as follows: CNA N had 10 hours and 38 minutes of documented training. CNA R had nine hours and 32 minutes of documented training. CNA Y had 10 hours and six minutes of documented training. Social Services Designee (SSD)/CNA X had nine hours and 24 minutes of documented training. On 10/24/24 at 10:00 AM, Administrative Staff A confirmed that CNAs were required to have 12 hours of training annually and stated there were no records of additional training for those CNAs. The facility did not provide a policy related to CNA continuing education and in-service training as requested on 10/24/24. The facility failed to ensure four of the five Certified Nurse Aides (CNA) sampled lacked the required 12 hours per year in-service training.