STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E546	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens County Hospital Ltcu Dba Pioneer Manor	1711 S Main Street Hugoton, KS 67951

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 46960 The facility reported a census of 73 residents with 18 residents sampled. Based on observation, interview, and record review, the facility failed to verify valid advanced directives (a legal document in which a person specified what actions should be taken for their health, which may or may not include a do not resuscitate [DNR - a decision whether or not to withhold medical intervention in the even the resident's heart stops] order) for three residents, Resident (R) 20, R60, and R72. These deficient practices had the potential to lead to uncommunicated needs specifically to end-of-life care. Findings included: - Review of the Electronic Health Record (EHR) on 12/09/24 at 10:47 AM for R20 revealed the following: 1. On 11/07/24 R20 had a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. 2. On the banner of the EHR, documentation indicated R20 had a valid DNR order. 3. The (Physician's) Orders tab lacked a DNR order. 4. The Resident Documents tab lacked documentation of a valid DNR. During an interview on 12/11/24 at 10:35 AM, Licensed Nurse (LN) G revealed staff knew which residents had a DNR order by the color of the lettering on the hallway nameplate to their room. LN G explained the black indicated that the resident was a full code (a technique of basic life support for the purpose of oxygenating the brain and heart until appropriate medical treatment can restore normal heart and ventilation action), and red indicated the resident was a DNR. LN G also stated there was a communication book in each house that had a list of residents and their preferences. LN G confirmed that R20's EHR lacked a DNR order or DNR form in the Resident Documents tab. Interview on 12/11/24 at 11:15 AM, Administrative Nurse B provided a copy of a prescription pad signed by a physician that documented R20 had a DNR order. Administrative Nurse B also confirmed, since it was not signed by the resident or the resident's representative and did not have a witness signature, the order was not valid (for advanced directives). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
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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	Review of the Electronic Health Record (EHR) on 12/09/24 at 12:47 AM for R62 revealed the following: 1. On 09/19/24 had a BIMS score of 99 which indicated the assessment could not be completed due to severely impaired cognition. 2. On the banner of the EHR, documentation indicated R62 had a valid DNR order. 3. The (Physician's) Orders tab lacked a DNR order. 4. The Resident Documents tab lacked documentation of a valid DNR. During an interview on 12/11/24 at 08:47 AM, Social Services Designee (SSD) D confirmed R62's EHR lacked a DNR form in the Resident Documents tab. During an interview on 12/11/24 at 02:18 PM, LN G stated residents should have the determination of full code versus DNR performed on admission, and the DNR paperwork should be signed by the resident or resident representative and witnessed and signed by a physician. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B confirmed that R62's EHR lacked a valid DNR order. Review of the Electronic Health Record (EHR) on 12/09/24 at 02:19 PM for R72 revealed the following: 1. On 11/14/24 had a BIMS score of 99 which indicated the assessment could not be completed due to severely impaired cognition. 2. On the banner of the EHR, documentation indicated R62 had a valid DNR order. 3. The (Physician's) Orders tab lacked a DNR order. 4. The Resident Documents contained a DNR form, but it was not signed by the physician. During an interview on 12/11/24 at 02:18 PM, LN G stated a resident's DNR paperwork should be signed by the resident or representative and witnessed and signed by a physician. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B confirmed R72's EHR lacked a valid DNR order. The facility did not provide a policy regarding advanced directives or DNR as requested on 12/12/24. The facility failed to verify valid advanced directives and/or DNR orders for three residents. This deficient practice had the potential to lead to uncommunicated needs regarding end-of-life care.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 73 residents with 18 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the [NAME] Data Set for three residents: R26 related to behavioral and emotional needs; R27 related to oxygen not captured; and 72 related to section GG coded incorrectly. Findings included: - During the onsite annual survey, the surveyor identified a concern regarding the accuracy of Minimum Data Set (MDS) assessments completed for three residents. Review of the Electronic Health Record (EHR) on 12/10/24 revealed the following comprehensive MDS noted concerns for the following three residents: R26's EHR recorded an Annual MDS, dated [DATE] and a Quarterly MDS, dated [DATE] revealed R26's behaviors were not captured on either MDS. Review of EHR targeted behavior charting on the medication administration record (MAR) during the look back period of MDS completed 07/25/24 and MDS completed on 11/10/24 revealed R26 had behaviors documented four out the seven days in lookback period. During an interview on 12/12/24 at 12:05 PM, Administrative Nurse C reported she was not aware to review the targeted behaviors documented on the MAR for behaviors. Administrative Nurse C confirmed she did not capture the behaviors. R27's EHR recorded an Annual MDS, dated [DATE] revealed R27's oxygen was not captured on MDS. During an interview on 12/11/24 at 04:28 PM, Administrative Nurse C reported the annual MDS did not capture the oxygen used by R27. R72's EHR recorded an Admission MDS, dated [DATE] revealed R72 required substantial to maximal assist for all of her activities of daily living (ADLs) and the Quarterly MDS dated , 11/14/24 revealed R72 required total assist with all ADLs. During an interview on 12/11/24 at 09:41 AM, Administrative Nurse C revealed that when she had completed R72's Quarterly MDS on 11/14/24 she realized that she had not captured R72's correct ADLs in section GG on the 08/19/24 Admission MDS. Administrative Nurse C revealed she had not realized to capture two or more assist required as a total. Additionally, she reported she did not think about correcting the 08/19/24 MDS until she was asked about a significant change during the interview. Administrative Nurse C reported that R27 had no change in ADLs since she had been admitted . During an interview on 12/12/24 at 08:41 AM, Certified Medication Aide (CMA) X reported that R72 had no change in her cares that were provided by staff, she reported that R72 had always been a total assist. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/24 at 11:34 AM, Administrative Nurse B reported she expected the MDS's to be completed accurately. The facility's policy Comprehensive assessment dated [DATE] documented the facility would conduct initial and periodic comprehensive, accurate, standardized, and reproducible assessments for each elder. The assessment would accurately reflect the elder's status at the time of the assessment. The sources of information for MDS included, review of elder's record, observation, communication with direct care staff, elder, and licensed nurses. If the MDS had been electronically submitted to Centers for Medicare & Medicaid Services, (CMS is the federal agency that provides health coverage) a correction would be submitted immediately to ensure accurate data collection. The facility failed to accurately complete the [NAME] Data Set for three residents: R26 related to behavioral and emotional needs; R27 related to oxygen not captured; and 72 related to section GG coded incorrectly. This placed the residents at risk for uncommunicated care needs.

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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 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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50659

The facility reported a census of 73 residents with 18 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately revise four residents care plans after psychotropic (alters mood or thought) medication changes for Resident (R) 62, R65, and R20. The facility did not revise the care plan for R20 and R24 to reflect pressure ulcer/injury (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) interventions. This failure placed the residents at risk for uncommunicated care needs.

Findings included:

- During the onsite annual survey, the surveyors identified a concern regarding the lack of updated care plan revisions and/or care plan revisions completed in a timely manner for R20, R24, R62, and R65.

R20's Electronic Health Record (EHR) revealed the care plan lacked a timely intervention for pressure ulcer that was discovered on 04/04/24. The care plan was revised on 08/08/24, four months after the pressure ulcer/injury was discovered. Additionally, R20's psychotropic medications Seroquel (is an antipsychotic medication used to treat major mental conditions which cause a break from reality that's used to improve mood, thoughts, and behaviors), ordered on 05/10/24, and R20's Buspirone (is a medication that treats anxiety), ordered 10/20/23, were medication changes not updated on his care plan.

R24's EHR revealed the care plan lacked a revision for an open area noted on the right mid back area when she readmitted to the facility on [DATE].

R62's EHR revealed the care plan lacked a revision to include any of the following psychotropic medication orders/changes as follows:

Prozac (is used to treat major depressive disorder) ordered on 11/02/24 and discontinued on 12/05/24. Lorazepam (medication used to treat anxiety) ordered on 05/24/24, an order to decrease doses, and eventually discontinue the administration on 12/05/24.

Seroquel ordered on 05/29/24 and discontinued on 12/05/24.

Trazodone (antidepressant medication) ordered on 12/05/24 for his depression.

R65's EHR revealed the care plan lacked revisions to reflect the changes in psychotropic medication as follows:

Trazadone was discontinued on 07/18/24 and Seroquel was discontinued on 11/07/24. However, those medications remained on the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lexapro (is a medication commonly used to treat depression and anxiety) ordered on 08/26/24 and the care plan lacked an update on the care plan. During an interview on 12/10/24 at 03:03 PM, Certified Nurse Aide (CNA) DD reported she would read the care plan, to know how to care for a resident. During an interview on 12/11/24 at 02:09 PM, Licensed Nurse (LN) U reported that Administrative Nurse B and Administrative Nurse C updated the residents care plans in the EHR. During an interview on 12/12/24 at 11:34 AM, Administrative Nurse B reported if the care plan change was needed for a restorative change, Certified Nurse Aide (CNA) Restorative Aide W would update the care plans electronically, after it was discussed with Administrative Nurse B and/or Administrative Nurse C. Administrative Nurse B reported that Administrative Nurse C updated the care plans and expected the care plans to be updated with in a couple of days. Administrative Nurse B reported that the household nurses do not feel comfortable to update the care plans in the EHR. The facility did not provide a policy regarding care plan revisions. The facility failed to revise four residents' care plans after pressure ulcer injuries occurred for R20 and R24. The facility failed to revise the care plan for R20 R62, and R65, regarding psychotropic medication changes.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility identified a census of 73 residents. The sample included 18 residents with one resident reviewed for discharge. Based on record review and interviews, the facility failed to ensure active discharge planning occurred for Resident (R) 75. This deficient practice had the risk for miscommunication of discharge goals and missed services for R75. Findings included: - R75 admitted to the facility on [DATE] and discharged on [DATE]. Review of the Electronic Health Record (EHR) for R75 included the following diagnoses: abnormal weight loss, urinary tract infection (UTI - an infection in any part of the urinary system), urosepsis (a condition where a urinary tract infection leads to a systemic infection that spreads throughout the body), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Admission Minimum Data Set (MDS) dated [DATE], documented R75 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented that R75 utilized a wheelchair, had an indwelling urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), R75 was always incontinent of bowel and was dependent on staff for all cares except eating which required substantial/maximal assistance. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 01/30/24, documented R75 required total assistance with most ADLs and was non-ambulatory (did not walk). The Quarterly MDS, dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The assessment documented R75 utilized a wheelchair, was dependent on staff for all cares and was always incontinent of bowel and bladder. The Care Plan dated 05/01/24, documented R75 did not have plans to discharge from the facility. The Care Plan documented that family did not feel that R75 would ever return home to live. The Progress Notes documented the following: On 09/19/24 at 02:16 PM, the author of the entry had been notified by family that R75 was going home and had received orders from the physician to discharge to home with all current orders and for R75 to follow up with the primary care provider (PCP) in two to four weeks. On 09/25/24 at 04:40 PM, R75 was discharged home accompanied by spouse. R75 and spouse were given a packet for community resources, spouse signed all paperwork and physician was aware of the discharge. R75's EHR lacked evidence of active discharge planning prior to his discharge on 09/25/24. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/24 at 04:15 PM, Administrative Nurse B and Administrative Nurse C confirmed that no discharge planning had occurred. The facility did not provide a policy related to discharge planning as requested on 12/12/24. The facility failed to ensure active discharge planning occurred for R75. This deficient practice had the risk for miscommunication of discharge goals and missed services for R51.

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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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable.

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

The facility had a census of 73 residents, with 18 sampled, and four reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to provide necessary services to maintain good personal hygiene for Resident (R)20, which placed R20 at risk for poor personal hygiene and related complications. The facility also failed to assist R72 to the dining area for meals or provide assistance with meals in her room, to help prevent the 10.75% weight loss over four months.

Findings included:

- Resident (R) 20's Electronic Health Record (EHR) included the following diagnoses: idiopathic peripheral neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet, caused by an unknown cause), pressure ulcer (any 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) to right plantar (walking surface) foot, venous hypertension (high blood pressure) with ulceration of right lower extremity, dementia (a progressive mental disorder characterized by failing memory, confusion), Methicillin-Resistant Staphylococcus Aureus (MRSA-a type of bacteria resistant to many antibiotics), excoriation (skin-picking [a mental disorder characterized by the repeated urge to pick at one's own skin]) disorder, anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), ataxia (inability to walk), and Wernicke's encephalopathy (presence of neurological symptoms related to depletion of thiamine [a B-vitamin] from excessive alcohol consumption).

The Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The assessment documented R20 was dependent on staff for assistance with lower body dressing and required substantial/maximal assistance with all other cares except eating which required setup or clean-up assistance and was frequently incontinent of bowel and bladder.

The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 08/17/24, documented the resident required assistance of two staff for most ADLs and R20 was no longer able to stand or ambulate (walk).

The Quarterly MDS dated [DATE] documented a BIMS score of six, which indicated severe cognitive impairment. The assessment documented R20 was dependent on staff for all cares except eating, which required setup or clean-up assistance and was frequently incontinent of bowel and bladder.

The 08/28/24 Care Plan documented R20 had impaired mobility due to recent hospitalization and included the following dated interventions:

03/06/23, R20 had incontinence if unable to make it to the bathroom on time and staff would utilize briefs to maintain personal hygiene and dignity.

08/08/24, R20 would be assisted to utilize bedpan and/or urinal or transfer to rolling shower/commode chair with two assist and split leg sling.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	08/08/24, R20 would utilize a full lift with two staff assistance and would be mobile with a wheelchair. 08/09/24, R20 would utilize a geri-chair for positioning. The Electronic Health Records (EHR) Physician Orders lacked active orders specific to ADL cares. During an observation on 12/11/24 at 08:20 AM, R20 sat in a geri-recliner in the dining area at a table with the morning meal present. R20 called out to the staff in the area and stated he needed assistance to the bathroom so he could move his bowels which was unacknowledged by any staff present in the area. At 08:25 AM, R20 called out to the staff in the area stating he had soiled his brief, which was unacknowledged by any staff present in the area. At 08:35 AM, an unknown staff member assisted the resident from left leaning to an upright position and placed a pillow between R20 and the left arm rail of the geri-recliner. R20 stated to the staff that his buttocks hurt, and he needed to utilize the bathroom, and the unknown staff did not acknowledge the resident's statement. At 08:50 AM, R20 sat in a geri-recliner and cried out to alert staff. Administrative Staff A sat with resident and was told by R20 that he needed to go to the bathroom. Administrative Staff A then told an unknown staff member that R20 had stated that he needed to go to the bathroom. Observation on 12/11/24 from 08:50 AM to 09:46 AM, R20 sat in a geri-recliner and cried out to alert staff and staff responded by asking R20 if he was hungry and provided additional food. R20 continued to state that he needed to go to the bathroom but was unacknowledged and unassisted by staff. Observation on 12/11/24 at 09:46 AM, Certified Nurse Aide (CNA) E approached R20 when he cried out for assistance. R20 told CNA E that he needed to go to the bathroom. CNA E alerted CNA F for assistance and assisted R20 to his room with his geri-recliner which was one hour and 26 minutes after R20 was first observed stating that he needed to go to the bathroom and one hour and 21 minutes after R20 stated that he had soiled his brief. CNA E and CNA F utilized the mechanical lift to assist R20 from his geri-recliner to the bed and performed incontinence care and discovered that R20 had a large BM and the intragluteal cleft was reddened. CNA staff alerted Licensed Nurse (LN) G to perform skin assessment and observed moisture-associated skin damage (MASD - an area of inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous to both inguinal (crease where the leg bone is joined to the trunk) folds and genitals and inside the intergluteal cleft (area of the body between the buttocks). CNA E and CNA F performed incontinence care and applied a white barrier cream to the areas of MASD and placed a clean brief on R20. During an interview on 12/11/24 at 10:10 AM, LN G stated R20's groin and intergluteal fold redness appeared to be blanchable MASD. During an interview on 12/11/24 at 10:35 AM, LN G confirmed R20 was in the dining area attempting to alert staff for over an hour and stated that R20 should have been assisted to the restroom as quickly as possible once R20 alerted staff that he needed to go to the bathroom. LN G said prolonged exposure of the skin to urine and or stool would contribute to skin breakdown as well as a negative effect on R20's dignity as this was not providing appropriate ADL care to a resident who was dependent on staff for cares. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/11/24 at 11:15 AM, Administrative Nurse B stated the observations of R20 (documented above) was an unacceptable delay in providing ADL care to a resident who was dependent on staff for assistance. Administrative Nurse B stated the prolonged exposure of urine or stool would contribute to skin breakdown and would have a negative affect on R20's dignity. Administrative Nurse B expected staff to assist residents to the bathroom as soon as possible, when alerted to the need. The facility's Pressure Ulcer Treatment and Prevention Policy, dated 10/2013 documented that all residents would be assessed for risk of and have interventions initiated to prevent impaired skin integrity that included to reduce or minimize excessive moisture on the skin by implementation of a toileting program and utilizing measures to contain incontinence. The facility lacked a policy related to ADL care of dependent residents as requested on 12/12/24. The facility failed to ensure staff provided prompt ADL care to dependent R20, when R20 requested toileting, and the staff did not provide the requested toileting care for one hour and 26 minutes. This failure placed R20 at risk for poor personal hygiene and at risk for skin breakdown. 50659 - Review of R72's diagnoses from the Electronic Health Record (EHR) included dementia (progressive mental disorder characterized by failing memory, confusion) and vitamin deficiency (is the condition of a long-term lack of a vitamin). The Annual Minimum Data Set (MDS) dated [DATE], documented R72 had moderately impaired cognition. The resident had a total mood severity score of 00, which indicated no depression. R72 displayed no behaviors and the resident required maximum assistance with activities of daily living (ADLs), to include eating, oral care, toileting, dressing, footwear, and personal hygiene. The MDS indicated R72 had no weight loss. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 08/23/24, documented R72 required two staff assistance with most of her ADLs. R72 required one staff assistance with meals and noted R72's intake would vary. At times R72 was alert and able to eat some and at times it was difficult to wake R72 up enough to eat. The Nutritional Status CAA dated 08/19/24, documented R72 was at a high risk for weight loss due to being a new admission and the change in lifestyle. The CAA noted the facility would proceed to care plan for monitoring of nutritional status and for monitoring of weight. The Quarterly MDS dated [DATE], documented R72 had moderately impaired cognition. The resident had a total mood severity score of 00, which indicated no depression and no behaviors. R72 was totally dependent for all ADLs and had no weight loss. The Care Plan dated 08/06/24, revealed R72 required staff assistance to go to and from meals. The staff were to assist the resident as needed with eating. R72's morning routine included to get up around 07:00 AM, staff were to assist R72 with ADLs, encourage R72 with oral intake of food and fluids, and offer R72 snacks in between meals and at bedtime, as she was often hungry. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Stevens County Hospital Ltcu Dba Pioneer Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1711 S Main Street Hugoton, KS 67951	

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician Orders documented R72 with a regular, no added salt diet, and finely chopped meats, dated 08/06/24. Review of weights in the EHR from 08/06/24 until 12/02/24 documented the following weights for R72: 08/06/24 at 03:39 PM weighed 93 pounds (lbs.). 08/19/24 (13 days since prior weight) at 01:09 PM weighed 94.8 lbs. 08/26/24 at 10:10 AM weighed 93.2 lbs. 09/02/24 at 03:43 PM weighed 89.8 lbs. 09/09/24 at 08:57 AM weighed 104 lbs. 09/10/24 at 09:15 AM weighed 103 lbs. 09/16/24 at 01:01 PM weighed 85.6 lbs. 09/23/24 at 10:46 AM weighed 94.6 lbs. 09/30/24 at 02:18 PM weighed 86.8 lbs. 10/14/24 (14 days since prior weight) at 03:39 PM weighed 86.6 lbs. 10/21/24 at 10:09 AM weighed 89.6 lbs. 10/28/24 at 03:30 PM weighed 85.4 lbs. 11/04/24 at 10:23 AM weighed 94.2 lbs. 11/18/24 (14 days since prior weight) at 11:19 AM weighed 92.6 lbs. 12/02/24 (14 days since prior weight) at 12:19 PM weighed 83.1 lbs A review of weights in EHR on 12/09/24 at 02:07 PM revealed on 08/06/2024, the resident weighed 93 lbs. On 12/02/24, the resident weighed 83 pounds which indicated a 10.75 % loss of weight. The 08/15/24 at 11:58 AM Dietary Progress Note revealed R72 received a regular diet, no added salt with finely chopped meats. R72 required assistance with meals. R72's weight was 93 pounds. The 12/01/24 at 12:17 PM Progress Note revealed staff reported R72 had a decrease in food intake. According to the report, R72 ate only jelly at lunch on 11/30/24. R72 slept all morning and was assisted up at lunchtime, where the resident consumed ice cream and a few bites of apples. During an observation on 12/09/24 at 07:53 AM and 09:07 AM, R72 remained in bed, and was not assisted to the dining room for breakfast. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During an observation on 12/09/24 at 10:13 AM, R72 remained in bed, eyes open and she reported she was thirsty. During an observation on 12/09/24 at 01:35 PM, R72 sat in the dining room and Certified Nurse Aide (CNA) S assisted the resident with eating. During an observation on 12/10/24 at 07:48 AM, and 08:36 AM, R72 was in her bed that was positioned low to the floor, both of her legs were hanging over the edge of the bed with feet on the floor mat, both of her eyes were closed. During an observation on 12/10/24 at 09:06 AM, CNA S entered R72's room to assist her. During an observation on 12/10/24 at 11:05 AM, R72 was in dining room eating her breakfast independently. During an interview on 12/11/24 at 02:46 PM, Licensed Nurse (LN) U reported staff assisted the residents up when they were awake, and the residents were not made to get up for meals. However, if the resident was not up for breakfast and lunch, they would be assisted up for the supper meal. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B reported R72 was discussed at the 12/05/24 risk meeting about the weight loss and reported no progress note was written. Administrative Nurse B was not sure why no new orders were obtained for her weight loss of 10.75%. Administrative Nurse B reported that was a significant weight loss and that was a concern. The facility's policy Weight Policy and Protocol dated 02/2018 documented the following: All elders of the facility will be evaluated for weight stabilization for timely identification of weight loss and treatment. Significant weight loss would be defined as five percent loss in 30 days and 10 percent loss in 180 days. The provider, elder, and or surrogate decision maker would be notified of the significant weight loss and would be referred to the Registered Dietitian immediately for assessment and recommendations. The facility failed to initiate weight loss interventions for cognitively impaired R72, who had an identified weight loss of 10.75% in four months. This deficient practice had the potential to negatively affect the resident's physical well-being.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51334 The facility identified a census of 73 residents, with 18 residents sampled, and four residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, interviews, and record review, the facility failed to prevent the development of pressure ulcers and failed to provide treatment to promote healing for two residents, Resident (R) 24 and R14, who both developed pressure ulcers while a resident at the facility. Findings included: - Resident (R) 24 's Electronic Health Record (EHR) revealed diagnoses of fractures (broken bones) to both upper arms, depression, Mantle cell lymphoma (a rare, aggressive type of blood cancer that affects the lymphatic system), abnormal weight loss, schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) spectrum disorder, and unspecified dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The MDS noted R24 had no behaviors and was dependent on staff for all activities of daily living (ADL). The assessment documented she did not have a pressure ulcer, but also documented she had one stage I pressure ulcer. The assessment documented the resident had a surgical wound, a pressure reducing device for her bed, pressure ulcer/injury care, surgical wound care, a non-surgical dressing, and ointments or creams other than to feet. The Pressure Ulcer CAA dated 11/10/24 documented R24 had a stage one pressure area to her coccyx that healed and returned. She sat or laid on her bottom frequently and chose not to reposition. The CAA documented the skin was red and blanchable. The Cognitive Loss/Dementia CAA dated 11/10/24 documented R24 had a BIMS score of 15 which indicated no cognitive impairment. She required two or three staff for assistance and two staff to assist her with bed mobility. She was not able to walk and required two to three staff to assist her with transfers. She was incontinent of bowel and had a foley catheter. She exhibited signs and symptoms of pain with movement due to a left wrist and left humerus fracture and a right humerus fracture. The 12/09/24 Care Plan documented the following dated interventions: 12/17/21, staff were to provide incontinence care after incontinence episodes and use moisture barrier and incontinence pads. The staff were to use heel protectors on the resident. The staff were to report any signs of skin breakdown like sore, tender, red or broken areas; avoid shearing skin during repositioning, transfer, and turning; and keep boney prominences cushioned with pillows, foam wedges, etc. 07/07/22, the care plan documented the resident sat for long periods of time in her recliner and refused to be repositioned. The staff were to ensure memory foam was on R24's bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/18/24, staff would add padding to the resident's chair or the wheelchair as needed when the resident was seated and use a gel cushion as needed. The resident was unable to fully reposition due to fractures on both arms and unable to shift her lower body, and she refused at times. R24 was to be up in her chair. The Physician Order dated 10/24/23, included a weekly skin assessment, vital signs, and charting once a week. The Physician Orders reviewed for 10/28/24 to 12/09/24 lacked any treatments for skin issues or pressure area. The Final Discharge Summary from the hospital dated 10/28/24 documented Follow wound care instructions per Physician CC]. The Braden with Skin Risk assessment dated [DATE] revealed the resident required the application of nonsurgical dressings (with or without topical medications) other than to feet, applications of ointments/medications other than to feet, and noted no current pressure ulcers. It also documented a pressure risk score of 14, which indicated a moderate risk for pressure ulcers. Review of the Progress Notes dated 10/28/24 at 06:29 PM, documented a dressing on her right shoulder with redness to right forearm. She wore slings on both arms for support. Her buttocks had minimal redness and she had a 2 centimeters (cm) by 1 cm sore on her right upper mid back with a foam dressing. Review of the Progress Notes dated 11/01/24 at 05:27 PM, the dressing on R24's right mid back was changed with no drainage. The wound was cleansed, and a foam wound dressing was applied. The Skin Assessment on 11/04/24 documented an open area on the resident's back towards the right side, an incision on her right shoulder with a dressing in place, a left wrist incision with a dressing and wrapped with ace wrap. The assessment documented no ulcers. The Skin Assessment on 11/11/24 documented a reddened non- blanchable area to her lower back with cream applied, and a dressing to her right shoulder. Review of the Progress Notes dated 11/15/24 at 01:42 PM, documented Steri-strips (adhesive wound closures) were in place on the right shoulder and left wrist incision sites and upper left arm. Redness was observed in her mid-back and a foam dressing was applied to relieve pressure on her back. A 1.5 cm by 3.5 cm stage 1 pressure injury was found on her right gluteus maximus. Staff were unable to apply a dressing. The resident had severe skin damage in the vaginal area and inner buttocks, redness and slight bleeding with barrier cream applied. The resident's provider was aware of resident's condition. The Skin Assessment on 11/18/24 documented the resident had no ulcers, documents multiple incisions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin Assessment on 11/25/24 documented the resident had skin tears on the right shoulder and left wrist. The resident had a 1 cm in width and 1.5 cm in length, pressure injury, stage I observed to the mid-back on the side of the spine. with Xeroform (occlusive wound dressing) dressing applied and covered with a foam dressing. Review of the Progress Notes dated 11/25/24 at 10:55 AM documented an excoriation to the resident's buttock with zinc cream applied. Staff observed a stage 1, 1 cm by 1.5 cm pressure injury on the resident's mid-back (spinal cord). Staff used Xeroform and covered the area with a foam dressing. The note documented the resident would be seen by the provider on 12/12/24 for further evaluation. Review of the Progress Notes dated 11/30/24 at 09:43 AM revealed the wound to the resident's mid back measured 0.5 cm in width and 1 cm in length. Redness was observed surrounding the wound. The area was cleansed with NS and patted dry, followed by the application of xeroform, then the wound was covered with a foam dressing. The Skin Assessment on 12/09/24 documented a 1 cm by 2 cm open lesion to the resident's mid back, with Xeroform dressing applied and covered with a non-adhesive dressing and noted no ulcers. During an observation on 12/10/24 at 08:49 AM, Licensed Nurse (LN) AA showed the surveyor the open area to R24's back, adjacent to her spine. The area had white debris covering about 30 percent of the wound bed, and redness around the wound. During an interview with LN AA at the same time, LN AA acknowledged it appeared to be slough (dead tissue, usually cream or yellow in color) in the wound bed and said it was a pressure ulcer. LN AA reported the nurse changed the dressing about every three days and said it was improving. During an interview on 12/11/24 at 09:41AM, Administrative Nurse C reported the facility had no wound nurse, that the household nurse would assess skin concerns weekly, and the physician would prescribe what treatment is to be completed. Additionally, she reported that if a wound treatment was not effective, the resident would receive and order to be assessed at the wound center. Administrative Nurse C could not provide a time frame on how long a resident would have to wait be assessed at the wound center. She reported that would be determined by the physician. Administrative Nurse C reported that when a resident was noted to have a new open area the household nurse would update Administrative Nurse B and physician. She also reported that the facility had standing orders. The Standing Orders policy was requested. During an interview on 12/11/24 at 01:50 PM, LN BB confirmed the staff received no wound care training. LN BB stated the nurse inspected the resident's skin when the resident was in the shower. LN BB stated the pressure ulcer on R24's back was there on reentry. LN BB said the staff had a book to show the (pressure ulcer) stages to assist with documentation. LN BB said it was a stage 3, but now had improved. LN BB stated they changed the dressing whenever it needed it and said it usually came off daily. During an interview on 12/11/24 at 02:35 PM, LN BB confirmed there were no treatment orders or dressing orders for any of the R24's wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/12/24 at 08:51 AM, Administrative Nurse B confirmed there was not a wound nurse. Also confirmed the information provided in the interview on 12/11/24 at 09:41AM with Administrative Nurse C. Administrative Nurse B reported that the nurses really could use updated training on wound care and prevention and had been looking at a program from another company for education. The Pressure Ulcer Treatment and Prevention Policy dated 10/2013 documented that the nurse will determine whether the ulcer is pressure related or non-pressure related and determine the stage. A description of the pressure ulcer including location, stage, dimensions, depth, the description of the wound base (granulation, necrotic tissue, eschar, slough, epithelial), drainage (amount, color, and odor), wound edges, odor, pain, and progress. Treatment of any new pressure ulcer will begin immediately upon discovery, document in the nurses' notes, and notify the physician and residents representative. The facility failed to document and place interventions to prevent worsening and address pressure injuries for R24, who developed a preventable, stage 3 pressure injury. 50659 - Resident (R) 14 's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and muscle weakness. The 11/12/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident had a total mood severity score of 00, which indicated no depression and R14 had no behaviors. R14 required total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, transferring, personal hygiene, and bathing. R14 required set-up for eating. He was occasionally incontinent of urine and frequently incontinent of bowel. The MDS identified R14 as at risk for pressure ulcers. No pressure related skin issues were identified on the assessment. R14 had a moisture-associated skin damage (MASD - caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration) and he had a pressure reducing device for his chair and bed. The 11/18/24 Pressure Ulcer/Injury Care Area Assessment (CAA) stated R14 was occasionally incontinent of bowel and bladder. He had a MASD upon admission and treatment was ongoing. He was not able to use briefs related to his skin breaks down with possibly an allergy to briefs. He used a disposable absorbent pad should he have an incontinent episode. Review of the resident's Care Plan on 12/09/24 revealed the following interventions: 10/31/24 - Staff were to reposition R14 frequently, R14 may choose not to reposition as times. Staff to cue and encourage R14 to reposition frequently to decrease pressure to any one area. Staff to provide education on the importance of this as needed. Staff to avoid shearing (the separation of skin layers caused by friction or trauma) skin during positioning and transferring. Staff to conduct a systematic skin inspection weekly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Staff to provide an alternate flow air mattress on the bed. Staff to avoid bony prominences from direct contact with one another, with pillows, foam wedges, and/or sheepskin. Staff instructed to keep the resident's skin clean and dry, as possible. Staff instructed to keep linens clean, dry, and wrinkle free, as much as possible. Staff instructed to keep head of the bed at the lowest degree of elevation as possible. Staff instructed to reduce friction injuries by using lubricants, protective films, dressings, and/or padding as needed. Staff instructed to report any signs of skin breakdown like sore, tender, red, or broken skin areas. Review of the Physician Orders documented the following: Weekly skin assessment once a day on Friday, date ordered 11/03/2024. Triamcinolone acetonide 0.1 % ointment (is used to treat the itching, redness, dryness, crusting, scaling, inflammation, and discomfort of various skin conditions) apply topically twice a day, to affected areas between flares when rash is fully resolved to prevent outbreaks, date ordered 11/07/24. Review of weights in the EHR from 10/30/24 until 12/02/24 documented the following weights for R14: 10/30/24 at 02:53 PM weighed 285 pounds (lbs.). 11/04/24 at 02:12 PM weighed 289.9 lbs. 12/02/24 at 01:19 PM weighed 334.8 lbs. Review of the Full Clinical Observation dated 10/30/24 at 05:22 PM, documented R14 had redness of the peri area noted. The 11/02/24 at 12:00 PM Progress Note revealed R14 requested to take a whirlpool bath and was unable to have that completed due his size. R14 had a skin rash with multiple open sores noted on the right buttock. The 11/03/24 at 05:20 PM Progress Note revealed R14 chose to stay in bed throughout the day. R14 was reluctant to reposition at first. After education R14 allowed staff to assist with repositioning. The 11/04/24 at 12:00 PM Progress Note revealed R14 had a large area of shearing noted to the right buttock, which measured approximately ten centimeters by five centimeters. A + D ointment (skin protectant ointment) applied mixed with Collagen (a protein that is used in wound care to help the body heal by stimulating new tissue growth) and covered with a large foam dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Weekly Skin assessment dated [DATE] at 11:34 AM, documented R14 had redness to the bilateral buttocks. No open areas were noted, and staff applied lotion. The 11/11/24 at 06:27 AM Progress Note revealed a Certified Nurse Aide reported R14 refused to be repositioned even though R14 was aware of the presence of multiple open areas and erythema (redness or inflammation of the skin) on his buttocks. Review of the Weekly Skin assessment dated [DATE] at 04:31 PM, documented R14 had erythema noted to buttocks, open area to right buttock, and staff applied an ointment. Review of the Weekly Skin assessment dated [DATE] at 11:37 AM (14 days since the prior skin assessment), documented the resident had redness to the buttocks, the right buttock had a dime sized open lesion, and staff applied lotion after his shower. Review of the Weekly Skin assessment dated [DATE] at 11:22 AM, documented no redness, staff applied Opti foam (a brand of foam wound dressings used to treat a variety of wounds, including pressure injuries, skin tears, and abrasions) to the right buttock, and applied lotion. Review of the Point of Care task charting from 10/30/24 through 12/09/24 lacked documentation of R14 refusing repositioning. During an observation on 12/09/24 at 08:26 AM, R14's air loss mattress was flat under R14 on his bed. The air mattress was plugged in, the green light was on, and the dial setting was set at four. R14 reported the air mattress had been flat since 12/08/24. During an observation on 12/10/24 at 07:50 AM, R14's air mattress was soft, the setting was set at four, and the green light was on. R14 reported he did not say anything to the staff about his mattress and he commented I would think they could see it was so soft and it was really not working from the waist down. During an observation on 12/10/24 at 08:46 AM, Certified Nurse Aide (CNA) S applied Triamcinolone acetonide 0.1 % ointment (used to treat skin conditions) and Zinc oxide cream (moisture barrier cream) mixed in her gloved hand to R14's buttocks which was very red in color, with several circular and irregular shaped superficial open areas noted on right buttocks, with base of wounds red in color and a small amount of sanguineous (bloody drainage) drainage noted from open areas. CNA S reported that R14's buttocks looked worse than the week before. Licensed Nurse (LN) T was present in R14's room at the time of observation and reported the household nurse was to a complete a weekly skin assessment, which included measurements and further stated the skin assessment had not been completed by her and she stated she did not have time to measure the open areas. Additionally, LN T reported the facility did not have a wound nurse. LN T applied an ABD pad (large pad to absorb drainage) to the resident's right buttock area after care was provided. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/10/24 at 09:00 AM, Certified Medication Aide (CMA) V reported that R14's air mattress was soft and did not know what the setting of four was on the air pump. She also did not know why R14's air pump setting had a X marked in black marker between numbers five and seven. CNA S reported R14 received a new air mattress in the last week and did not know what the setting numbers on the air pump indicated. CMA V reported that Restorative Aide W was the staff member that decided if an air mattress was used and would be the staff member to ask about the number settings. CNA S reported Maintenance Staff N was aware on 12/09/24 the air mattress was not working per LN T. During an interview on 12/10/24 at 09:33 AM, CNA Restorative Aide W reported the air mattress was implemented on admission, and Maintenance Staff N knew on 12/09/24 that R14's air mattress had a problem. CNA W reported she did not go look at R14's air mattress on 12/09/24. CNA W reported the facility did have back up air mattresses and pumps in storage, but it usually would take a day to have the mattress taken care of as nursing staff do not replace equipment. CNA W reported she would check with a maintenance staff member today. CNA W reported the setting on the dial for air mattress pump was generally set between five and seven for comfort and was not based on weight. During an interview on 12/10/24 at 11:25 AM, LN T reported R14's air mattress on his bed did not have a date when it was applied and reported that R14's air mattress would get firmer when R14 was not in bed. She also reported maintenance was updated on 12/09/24 that the air mattress was soft. LN T further reported maintenance was updated verbally, or a note was placed on their door or desk in the maintenance office, when there was a maintenance concern. During an interview on 12/10/24 at 11:35 AM, Maintenance Staff N reported air mattresses purchased for the facility had a weight limit of 250 pounds and reported that R14 weighed more than the weight limit. Maintenance Staff N reported that he changed out the air mattress last week and did know yesterday that R14's air mattress was not functioning properly. During an interview on 12/11/24 at 09:41AM, Administrative Nurse C reported the facility had no wound nurse, the household nurse would assess skin concerns weekly, and the physician would prescribe treatment for the wounds. Administrative Nurse C reported that if a wound treatment was not effective, the facility would obtain an order for the resident to be assessed at the wound center. Administrative Nurse C could not provide a time frame on how long a resident would have to wait be assessed at the wound center and stated that would be determined by the physician. Administrative Nurse C reported when a resident was noted to have a new open area the household nurse would update Administrative Nurse B and the physician. She also reported that the facility had standing orders for wound treatments. During an interview on 12/11/24 at 02:31 PM, LN U reported he did not measure the redness on R14's buttocks when he admitted to the facility, and he had only measured the right buttock open area one time on 11/04/24. LN U reported there was no wound nurse and could not recall if the provider was updated. LN U reported he used the standing orders for treatment to the area. LN U reported he would not stage the area on the right buttock, he did not know the air mattresses had a weight limit, and the settings on the air pump were set for residents' weight. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Stevens County Hospital Ltcu Dba Pioneer Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1711 S Main Street Hugoton, KS 67951	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B reported R14's air mattress was a concern. Additionally, she reported that no one knew that the air mattresses had a weight limit or what the numbers on the setting of air pump were for. Administrative Nurse B reported that CNA W would receive direction from Administrative Nurse C or herself to apply an air mattress to resident's bed. She expected the household nurse to complete a thorough skin assessment weekly, which included measurements. Administrative Nurse B reported R14 should have had more consistent documentation for his refusal of care and could not state what the CNA's should be charting in point of care. Administrative Nurse B reported the nurses really could use updated training on wound care and prevention and had been looking at a program from another company. Review of the facility's undated Operating Manual Air Pro Elite Alternating Pressure Pad and Pump documented the following: Pump setting chart patient weight lbs. 85-140 lbs. setting to be set at one to two. 120 - 165 lbs. setting to be set at two to four. 150 - 195 lbs. setting to be set at three to five. 175 - 205 lbs. setting to be set at four to seven. 200 - 250 lbs. setting to be set at five to eight. Review of the undated Air - Pro mattress specifications provided by facility documented the air mattress purchased had a weight limit of 250 lbs. Review of the facility's Pressure Ulcer Treatment and Prevention dated 10/2013 documented the following: All residents will be assessed for risk for developing pressure ulcers and interventions to prevent impaired skin integrity. A resident who develops pressure ulcers shall receive appropriate monitoring and treatments to promote healing. When assessment of the ulcer is completed, staff are to determine the stage of the ulcer, document a description of the ulcer (which should include measurements, drainage, wound edges, pain) and document progress of ulcers. The facility failed to place an appropriate weight-based intervention to prevent pressure injuries for R14, who developed multiple preventable, facility acquired, stage two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure injuries. Additionally, the facility failed to monitor, measure, and assesses R14's skin consistently. This placed the resident at risk to worsen his current pressure ulcers and/or develop more skin issues.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51332 The facility census totaled 73 residents with 18 residents included in the sample with 11 residents reviewed for accident hazards failed to identify and remove accident hazards for three dependent residents, Resident (R) 65 related to staff not using fall mats as directed, R20 with incorrect use of a mechanical lift, and R60 left unattended with a disposable razor in reach and his emergency call light out of reach. These deficient practices had the potential to lead to accidents that would negatively affect the resident's physical and psychosocial well-being. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 60 included the following diagnoses: Anxiety disorder(a disorder characterized by chronic free-floating anxiety), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depressive episodes (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion), behavioral disturbance (a range of behaviors that can be caused by a number of conditions, including dementia, disruptive behavior disorders, and acute behavioral disturbance), and disorder of adult personality and behavior (a mental health condition that involves long-lasting, all-encompassing, disruptive patterns of thinking, behavior, mood and relating to others). The Annual Change Minimum Data Set (MDS) dated [DATE], documented staff assessed R 60 as having severely impaired cognition. The assessment documented R60 was dependent on assistance from staff for transfers and dependent on staff to perform other cares. R60 received antipsychotic medication during the look back period. The Quarterly MDS dated [DATE], documented a BIMS of 00, which indicated severely impaired cognition. R60 received an antipsychotic medication. The Cognitive Loss/Dementia (CAA) dated 06/27/24, documented R60 was on Risperdal (Antipsychotic-class of medications used to treat psychosis and other mental emotional conditions) routinely for diagnosis of psychosis with delusions. Review of the Progress Note dated 12/10/24 at 08:30 AM revealed R60 made statements to Administrative Nurse B stating, I am going to die tomorrow and other statements regarding his death. The statements were reported to Social Services Designee (SSD) D. Review of the Progress Note dated 12/11/24 at 04:35 PM revealed the Licensed Nurse (LN) M, documented that it was reported R60 stated that (he) wants to die. Observation on 12/12/24 at 07:52 AM revealed a disposable razor within reach of the resident. Observation on 12/12/24 at 08:23 AM revealed R60's call light was not in reach and tucked under the resident's pillow with a disposable razor within reach, and the resident alone in the room yelling out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/12/24 at 08:54 AM revealed R60's call light laid on the floor and out of reach for the resident and the disposable razor remained within reach of the resident. On 12/12/24 at 04:23 PM, Administrative Staff B stated It was not appropriate to not have a call light within reach and a disposable razor within reach for R60. On 12/12/24 at 04:23 PM, Administrative Staff A stated it was not appropriate for R60 to not have call light within reach and disposable razor within reach. The facility failed to provide a policy related to accident hazards. The facility failed to identify and remove accident hazards for R60 when staff failed to ensure the resident had an emergency call light within reach and failed to remove a disposable razor from the resident's bedside and outside of reach for the resident. 46960 - Resident (R) 20's Electronic Health Record (EHR) included the following diagnoses: idiopathic peripheral neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet, caused by an unknown cause), pressure ulcer (any 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) to right plantar (walking surface) foot, venous hypertension (high blood pressure) with ulceration of right lower extremity, dementia (a progressive mental disorder characterized by failing memory, confusion), Methicillin-Resistant Staphylococcus Aureus (MRSA-a type of bacteria resistant to many antibiotics), excoriation (skin-picking [a mental disorder characterized by the repeated urge to pick at one's own skin]) disorder, anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), ataxia (inability to walk), and Wernicke's encephalopathy (presence of neurological symptoms related to depletion of thiamine [a B-vitamin] from excessive alcohol consumption). The Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The assessment documented R20 was dependent on staff for assistance with lower body dressing and required substantial/maximal assistance with all other cares except eating which required setup or clean-up assistance and was frequently incontinent of bowel and bladder. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 08/17/24, documented the resident required assistance of two staff for most ADLs and R20 was no longer able to stand or ambulate (walk). The Quarterly MDS dated [DATE] documented a BIMS score of six, which indicated severe cognitive impairment. The assessment documented R20 was dependent on staff for all cares except eating, which required setup or clean-up assistance and was frequently incontinent of bowel and bladder. The 08/28/24 Care Plan documented R20 had impaired mobility and was a high fall risk listed the following interventions: On 08/08/24, R20 required the use of a full (mechanical) lift for mobility and transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24, R20 would be transferred with a full (mechanical) lift and assistance of two staff for all mobility. On 09/25/24, R20 would be transferred with full (mechanical) lift and assistance of two staff. Observation on 12/11/24 at 09:46 AM, Certified Nurse Aide (CNA) E and CNA F utilized full mechanical lift to transfer R20 from the geri-recliner to his bed. CNA E positioned the geri-recliner at approximately a 45-degree angle and approached R20's upright geri-recliner with the full mechanical lift from the side. CNA E and CNA F then lowered the full mechanical lift into position and connected the bar to the sling under the resident and CNA D lifted the resident into the air with the full mechanical lift while CNA F maintained contact with R20. CNA F then let go of R20 while CNA E pulled the full mechanical lift backwards and R20 swung independently while CNA F repositioned the geri-recliner to allow the full mechanical lift to be moved into position over R20's bed. R20 was lowered onto the bed and incontinence care was performed by CNA E and CNA F. R20 was then lifted back into the air using the full mechanical lift and CNA E backed the lift away from the bed with CNA F holding on to R20. CNA F then let go of R20 and swung independently while CNA F positioned the geri-recliner at approximately a 45-degree angle to the full mechanical lift and CNA E lowered R20 into the upright chair with CNA F stabilizing R20's descent into the chair. Interview on 12/11/24 at 10:16 AM, CNA E and CNA F revealed that their training was to utilize the full mechanical lift at a 45-degree angle when residents were seated in geri-recliners because the geri-recliners would not fit between the legs of the full mechanical lift straight on. Interview on 12/11/24 at 10:35 AM, Licensed Nurse (LN) G revealed that the full mechanical lift should be placed directly in front of the resident and the legs of the full mechanical lift should be opened to provide more room for the wheelchair or geri-recliner to fit between the legs, and one staff member should always hold onto the resident for safety. Interview on 12/11/24 at 11:15 AM, Administrative Nurse B revealed that during a full mechanical lift, one staff would operate the lift while the other staff would stabilize the resident to ensure safety. Administrative Nurse B stated that it was acceptable practice to operate the lift at an angle from the chair if the chair would not fit between the legs of the lift but was unsure what the policy documented for correct procedure. The facility's Pioneer Manor Mechanical Lift Transfer policy, dated 08/02/19, documented that staff would position the base of the lift appropriate to the position of the resident: directly in front of a seated resident, or perpendicular (right angle [90-degree angle]) to a bed or reclining resident. The facility failed to provide an environment free of accident hazards when on 12/11/24 staff failed to correctly utilize a full mechanical lift with R20. This deficient practice had the potential to lead to accidents that would negatively affect R20's physical and psychosocial well-being.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility identified a census of 73 residents with 18 sampled. Based on observation, interview, and record review, the facility failed to initiate weight loss interventions for cognitively impaired Resident (R) 72, who had an identified weight loss of 10.75% in four months. This deficient practice had the potential to negatively affect the resident's physical well-being. Findings include: - Review of R72's diagnoses from the Electronic Health Record (EHR) included dementia (progressive mental disorder characterized by failing memory, confusion) and vitamin deficiency (is the condition of a long-term lack of a vitamin). The Annual Minimum Data Set (MDS) dated [DATE], documented R72 had moderately impaired cognition. The resident had a total mood severity score of 00, which indicated no depression. R72 displayed no behaviors and the resident required maximum assistance with activities of daily living (ADLs), to include eating, oral care, toileting, dressing, footwear, and personal hygiene. The MDS indicated R72 had no weight loss. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 08/23/24, documented R72 required two staff assistance with most of her ADLs. R72 required one staff assistance with meals and noted R72's intake would vary; at times she was alert and able to eat some and at times it was difficult to wake R72 up enough to eat. The Nutritional Status CAA dated 08/19/24, documented R72 was at a high risk for weight loss due to being a new admission and the change in lifestyle. The CAA noted it would proceed to care plan for monitoring of nutritional status and for monitoring of weight. The Quarterly MDS dated [DATE], documented R72 had moderately impaired cognition. The resident had a total mood severity score of 00, which indicated no depression and no behaviors. R72 was totally dependent for all ADLs and had no weight loss. The Care Plan dated 08/06/24, revealed R72 required staff assistance to go to and from meals. The staff were to assist the resident as needed with eating. R72's morning routine included to get up around 07:00 AM, staff were to assist R72 with ADLs, encourage R72 with oral intake of food and fluids, and offer R72 snacks in between meals and at bedtime, as she was often hungry. The staff were to obtain weekly weights for R72 and notify the provider and family of significant weight changes. Review of the Physician Orders documented R72 with a regular, no added salt diet, with finely chopped meats, dated 08/06/24. Review of weights in the EHR from 08/06/24 until 12/02/24 documented the following weights for R72: 08/06/24 at 03:39 PM weighed 93 pounds (lbs.). 08/19/24 (13 days since prior weight) at 01:09 PM weighed 94.8 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	08/26/24 at 10:10 AM weighed 93.2 lbs. 09/02/24 at 03:43 PM weighed 89.8 lbs. 09/09/24 at 08:57 AM weighed 104 lbs. 09/10/24 at 09:15 AM weighed 103 lbs. 09/16/24 at 01:01 PM weighed 85.6 lbs. 09/23/24 at 10:46 AM weighed 94.6 lbs. 09/30/24 at 02:18 PM weighed 86.8 lbs. 10/14/24 (14 days since prior weight) at 03:39 PM weighed 86.6 lbs. 10/21/24 at 10:09 AM weighed 89.6 lbs. 10/28/24 at 03:30 PM weighed 85.4 lbs. 11/04/24 at 10:23 AM weighed 94.2 lbs. 11/18/24 (14 days since prior weight) at 11:19 AM weighed 92.6 lbs. 12/02/24 (14 days since prior weight) at 12:19 PM weighed 83.1 lbs During a review of weights in EHR on 12/09/24 at 02:07 PM. On 08/06/2024, the resident weighed 93 lbs. On 12/02/2024, the resident weighed 83 pounds which is a -10.75 % Loss. The 08/15/24 at 11:58 AM Dietary Progress Note revealed R72 received a regular diet, no added salt with finely chopped meats. R72 required assistance with meals. R72's weight was 93 pounds. The 11/21/24 at 12:07 PM Dietary Progress Note revealed R72 received a regular diet, no added salt with finely chopped meats. R72 required assistance with meals. R72's weight was 92.6 pounds. R72's weight history had fluctuated since admission on 08/06/24, with a weight range between 84-94 pounds. The 12/01/24 at 12:17 PM Progress Note revealed staff reported R72 had a decrease in food intake. According to the report, R72 ate only jelly at lunch on 11/30/24. R72 slept all morning and was assisted up at lunchtime, where the resident consumed ice cream and a few bites of apples. During an observation on 12/09/24 at 07:53 AM and 09:07 AM, R72 remained in bed, and was not assisted to the dining room for breakfast. During an observation on 12/09/24 at 10:13 AM, R72 remained in bed, eyes open and she reported she was thirsty. During an observation on 12/09/24 at 01:35 PM, R72 sat in the dining room and Certified Nurse Aide (CNA) S assisted the resident with eating. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an observation on 12/10/24 at 09:06 AM, CNA S entered R72's room to assist her. During an observation on 12/10/24 at 11:05 AM, R72 was in dining room eating her breakfast independently. During an interview on 12/11/24 at 10:29 AM, Registered Dietician Y reported that weight loss for all residents was addressed at the weekly risk meeting. Registered Dietician Y would receive the information from Administrative Nurse C. Registered Dietician Y reported that R72's weight loss was discussed on 12/05/24 and reported he was not sure if the weight loss was a true weight loss, and this was his first day back since that meeting. He reported that the facility had a weight loss protocol and R72 was not started on any dietary interventions after that meeting and she would need to start on supplements due to the 10 percent weight loss noted in four months. During an interview on 12/11/24 at 02:46 PM, Licensed Nurse (LN) U reported staff assisted the residents up when they were awake, and the residents were not made to get up for meals. However, if the resident was not up for breakfast and lunch, they would be assisted up for the supper meal. LN U reported if there was a three-pound weight loss or weight gain noted when resident was weighed, the resident would have to be re-weighed. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B reported that R72 was discussed at the 12/05/24 risk meeting about the weight loss and reported no progress note was written. Administrative Nurse B was not sure why no new orders were obtained for her weight loss of 10.75%. Administrative Nurse B reported that was a significant weight loss and that was a concern. During an observation on 12/12/24 at 08:20 AM, Certified Medication Aide (CMA) X zeroed the wheelchair scale and weighed R72's empty wheelchair with the chair cushion and foot pedals attached. CMA X noted the weight of 44.6 lbs. During an observation on 12/12/24 at 08:40 AM, CMA X weighed R72 on the wheelchair scale, and noted a weight of 128.8 lbs. CMA X completed the math and reported R72 weighed 84 pounds. CMA X reported that the nurse on the unit was updated with all the weights that were completed. During an interview on 12/12/24 at 10:16 AM, Administrative Nurse C reported that residents' weights were reviewed weekly at the risk meeting. She reported if the CNA observed a change in the weight, the CNA would update the household nurse, and the household nurse would update Administrative Nurse B. Administrative Nurse C confirmed that R72's weight was 84 pounds and the EHR lacked documentation of progress notes and orders for supplements for weight loss that had occurred. Administrative Nurse C reported that R72 was discussed 12/05/24 risk meeting. The facility's policy Weight Policy and Protocol dated 02/2018 documented the following: All elders of the facility will be evaluated for weight stabilization for timely identification of weight loss and treatment. Significant weight loss would be defined as five percent loss in 30 days and 10 percent loss in 180 days. The provider, elder, and or surrogate decision maker would be notified of the significant weight loss and would be referred to the Registered Dietitian immediately for assessment and recommendations. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility failed to initiate weight loss interventions for cognitively impaired R72, who had an identified weight loss of 10.75% in four months. This deficient practice had the potential to negatively affect the resident's physical well-being.

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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. 51332 The facility reported a census of 73 residents with 18 in the sample revied six for respiratory care. Based on observation, interview, and record review, the facility failed to provide respiratory care and services including the safe handling, storage, and dispensing of oxygen consistent with professional standards of practice for five residents, Residents (R)11, R27, R16, R60, and R42 to prevent the spread of illnesses. Findings included: - Observation on 12/09/24 at 09:44 AM revealed R11's oxygen tubing dated 12/09/24 connected to the concentrator and the nasal cannula hanging off the humidifier bottle. Observation on 12/09/24 at 11:44 AM revealed R27's oxygen tubing with the excess cannula tubing coiled on floor behind concentrator. Observation on 12/10/24 at 07:53 AM revealed R16's oxygen tubing laid in a basket on the resident's bedside table and another unused oxygen tubing shoved in basket beside recliner. Observation on 12/10/24 at 08:20 AM revealed R60's oxygen nonrebreather-mask was draped over the resident's oxygen concentrator, unplugged, with the mask touching the floor. Observation on 12/10/24 at 08:20 AM revealed Certified Nurse Aide (CNA) J wrapped up CNA J's oxygen tubing and placed it on top of the oxygen concentrator before leaving the room. Observation on 12/11/24 at 04:28 PM revealed R42's nasal cannula on the floor of her room with concentrator the on and the resident out of the room. On 12/11/24 at 10:13 AM, an interview with CNA L reveled when oxygen was not in use the tubing/nasal cannula should have been placed in a bag and off the ground. On 12/11/24 at 10:51 AM, an interview with Licensed Nurse (LN) M revealed oxygen tubing was to be changed out during the night shift by the nurse every other Saturday. On 12/12/24 at 08:51 AM, an interview with Administrative Nurse B revealed oxygen tubing should be stored somewhere other than the floor or in bed with the residents, stated that recently had done away with the plastic bags due to it not being a home-like environment and has not come up with a non-plastic bag solution yet, so the plastic bags were removed. The facility's policy Pioneer Manor Administration of Oxygen dated 09/09/19 reveled all nasal cannulas, and nebulizer masks are to be stored in plastic bags when not in use, disposable cannulas, nebulizer masks, and tubing will be changed out weekly on the night shift and plastic storage bags will be changed and dated daily on the night shift, changes will be documented on the electronic health record. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide respiratory care and services including the safe handling, storage, and dispensing of oxygen consistent with professional standards of practice for Residents (R)11, R27, R16, R60, and R42 to prevent the spread of illnesses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E546	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens County Hospital Ltcu Dba Pioneer Manor	1711 S Main Street Hugoton, KS 67951

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 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 mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 73 residents, with 18 residents in the sample, and one resident reviewed for treatment/services for mental and psychosocial concerns. Based on observation, interview, and record review the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R) 5, who had been sad and tearful since admission on 06/28/23. Findings included: - Review of the Electronic Health Record (EHR), documented R5 had diagnoses, which included dementia (a progressive mental disorder characterized by failing memory and confusion) and depression. The 05/23/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R5's total mood severity score of 00, indicated no depression. The MDS documented the resident did not have behaviors during the look back period. R5 was independent with all his activities of daily living (ADL) except she required a set up for eating. R5 required antianxiety (class of medications that calm and relax people) and antidepressant (class of medications used to treat mood disorders) medications on a routine basis. The 06/04/24 Psychotropic Medication Use Care Area Assessment (CAA) documented R5 had no signs or symptoms of depression. However, she did have a diagnosis of depression and she would be administered Sertraline (an anti-depressant) routinely for this and Buspirone (a medication that treats anxiety), routinely for her anxiety. The 06/04/24 Cognitive Loss and Dementia CAA documented R5 was alert and oriented most times and had an increase in confusion and forgetfulness noted at times. R5 has a diagnosis of dementia and was at risk for increased disorientation. The 11/07/24 Quarterly MDS documented the resident had a BIMS score of 13, which indicated intact cognition. No depression or behaviors were noted on the assessment. R5 remained on antianxiety and antidepressant medications on a routine basis. Review of the resident's Care Plan on 12/09/24 revealed the following interventions: 06/29/23 - Staff were instructed to assess if R5's behavior and/or mood symptoms were present to herself or others. Staff were instructed to attempt a gradual dose reduction when and if ordered. Staff would monitor the effectiveness of medications. The pharmacy consultant and Physician would review medications regularly. Staff were instructed to document R5's behaviors and mood. 06/05/24 - Staff were instructed to monitor R5 for being tearful and provide one-on-one to express her feelings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician Orders documented the following: Buspirone 10 milligram (mg) tablet, take one tablet, by mouth, three times a day, related to anxiety, ordered on 06/29/23. Sertraline 25 mg tablet, take one tablet, by mouth once a day, related to depression, ordered on 06/29/23. Sertraline 50 mg tablet, take one tablet, by mouth, once a day with 25 mg tablet to equal 75 mg, related to depression, ordered on 06/29/23. The Physician Orders lacked an order to monitor and document targeted behaviors. On 07/29/23 at 12:00 PM, the Progress Note revealed R5 was upset, requested her phone that her daughter removed from the facility. R5 was offered a cordless phone to call her family member. On 11/18/23 at 08:28 AM, the Progress Note revealed R5 requested to speak to a therapist to discuss her depression. The nurse sent the physician a written communication to address R5's concern. On 11/22/23 at 01:57 PM, the Progress Note revealed physician reviewed R5's request to see a therapist and ordered R5 to be referred to a behavioral health provider. On 06/05/24 at 11:41 AM, the Progress Note revealed R5 was tearful that family member would be moving away and reported that she felt alone as no one would be close to her now. On 08/05/24 at an unknown time, the Pharmacy Recommendation from Pharmacist revealed the resident's current dose of Buspirone was ordered as a 10 mg tablet three times a day and recommended a trial of 10 mg twice a day at this time was appropriate. The physician responded with patient is barely stable. On 08/11/24 at 01:45 PM, the Assessment Psychoactive Medication Quarterly Evaluation revealed R5 received a Buspirone 10 mg tablet by mouth three times a day for anxiety and Sertraline 75 mg tablet by mouth daily for depression. The assessment noted the behaviors warranting use of medication as depression and anxiety. R5 had crying episodes three times a week. On 11/02/24 at 02:44 PM, the Assessment Psychoactive Medication Quarterly Evaluation revealed R5 received Buspirone 10 mg tablet by mouth three times a day for anxiety and Sertraline 75 mg tablet by mouth daily for depression. The behavior warranting use of the medication was depression and anxiety. R5 was tearful and voiced frustration about her family member three times a week. On 11/29/24 at 11:25 PM, the Progress Note revealed R5 continued to be sad, tearful, and wanted to call her family. On 12/01/24 at 09:49 PM, the Progress Note revealed R5 had been really sad and wanted to call her family. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/24 at 08:56 AM, R5 reported she was sad, and she had tears in her eyes. She reported that she had to live at the facility and did not know why. She reported she missed her dog and R5 started to cry. R5 reported that she never saw her family members and reported she felt like no one cared. During an observation on 12/10/24 at 07:49 AM, R5 was taking a shower independently in her bathroom. During an interview on 12/10/24 at 08:37 AM, R5 became tearful again when she talked about her dog, and reported when she first moved in facility it was a blur to her. During an interview on 12/10/24 at 09:05 AM, Activity Director EE reported R5 would come to activities often and assist with crafts. Activity Director EE reported R5 would get tearful and upset when she spoke about her family. During an interview on 12/10/24 at 02:32 PM, Certified Medication Aide (CMA) X reported R5 would get tearful and upset at times when she spoke about her dog and family. CMA X reported she would listen to R5 when she was sad. During an interview on 12/11/24 at 08:47 AM, Social Service Designee (SSD) D reported she was not aware that R5 had an order to see a behavior therapist on 11/2023. SSD D reported R5 was on the list to see the new behavioral health provider that started at facility on 12/05/24. SSD D revealed she did not document in the resident's EHR about the new behavioral health services for R5 and confirmed that R5 had depression and would cry. SSD D reported that the nurses on the household would document behaviors. During an interview on 12/11/24 at 09:41 AM, Administrative Nurse C reported R5 would use the facility cordless phone to call family and was not aware that a family member had taken her cell phone away. Administrative Nurse C reported R5 would be tearful quite often. During an interview on 12/11/24 at 02:55 PM, Licensed Nurse (LN) reported R5 should have targeted behavior charting completed and confirmed that was not in EHR. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B reported she expected the household nurses to complete targeted behaviors on residents that were administered psychotropic medications. She reported that she did not know why R5 did not have that monitoring on her orders. Administrative Nurse B revealed she was not aware that R5 had an order on 11/22/23 to see a behavior therapist and reported that she could not locate the physician to nurse communication order that was documented in the EHR. She reported that there had been an issue in the past when the orders were gathered off the households to be uploaded in EHR. Administrative Nurse B reported that R5 was still tearful and that she was on the list to see the new behavior health provider. The facility did not provide a policy for Treatment and Services for Mental and Psychosocial Concerns. The facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for R5, who remained tearful and sad since she was admitted on [DATE].

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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. 50659 The facility reported a census of 73 residents with 18 residents selected for review. Based on observation, interview, and record review, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) (a rating scale to measure involuntary movements known as tardive dyskinesia [TD is abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk]) assessment for two of the five residents reviewed for unnecessary medications, Resident (R) 62 and R20, who received Seroquel (antipsychotic- class of medications used to treat major mental conditions which cause a break from reality). The facility failed to provide a rationale regarding why the Pharmacy recommendation for a gradual dose reduction (GDR, to gradually reduce the dose of certain medications) for R20's Seroquel was not completed. Findings include: - During the onsite annual survey, the surveyors identified a concern regarding the AIMS assessments not completed for R62 and R20, when they both received Seroquel routinely. Additionally, R20 had a GDR recommendation completed by pharmacy review and the physician did not provide a rationale for declining the GDR. R62's Electronic Health Record (EHR) revealed R62 received Seroquel 05/29/24 through 06/19/24 on a routine basis for diagnosis of dementia. Additionally, the diagnosis was changed on 06/19/24 through 12/05/24 to restlessness and agitation. The EHR revealed the AIMS assessments was not completed when R62 received Seroquel those seven months. The Physicians Orders for R62 documented Seroquel 25 milligram (mg) tablet, give 12.5 mg tablet, by mouth, at bedtime for dementia, date ordered 05/29/24. Review of R62's Medication Regimen Review (MRR) dated 06/13/24 through 11/04/24 documented no recommendations at this time for any psychoactive medication. The pharmacist did not address the daily administration of R62's Seroquel for a diagnosis of dementia, restlessness, and agitation. Furthermore, no recommendation noted for an AIMS assessment to be completed. Review of R62's MRR dated 11/04/24, revealed the pharmacist recommend a GDR for R62's Lorazepam (antianxiety medication) and Fluoxetine (antidepressant medication). The provider reviewed the recommendation on 11/27/24 and wrote no change, R62 would be seen by psych soon. Review of 62's MRR dated 12/03/24, pharmacist recommended a GDR for Seroquel 12.5 mg at bedtime to taper off completely. R62 had a behavioral health consult completed on 12/05/24, R62 received new orders to have Fluoxetine and Seroquel discontinued, and a reduction of Lorazepam to continue and plan to taper R62 off that medication. R62 received a new order for Trazadone (an antidepressant medication) give 25 mg tablet, by mouth daily and 50 mg tablet, by mouth at bedtime for the diagnosis of severe major depression, and an as needed order for Trazodone 25 mg tablet, by mouth daily as needed for seven days for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R20's EHR revealed R20 received Seroquel 12.5 mg tablet, one tablet, by mouth at bedtime dated ordered, 05/17/24 on a routine basis for a diagnosis of dementia. Additionally, R20 received Buspirone (is an anxiolytic agent (used for short-term treatment of generalized anxiety and second-line treatment of depression) 5mg tablet, give one tablet, by mouth, twice daily, for anxiety disorder, date ordered 10/23/23. Review of the EHR revealed R20 had an AIMS assessment completed on 02/15/24, 05/05/24 and 08/11/24 and they had a score of one. The EHR revealed an AIMS assessment had not been completed from 08/12/24 through 12/10/24. On 06/11/24, the MRR was completed, pharmacist recommended a GDR for Buspirone. R20 had been receiving Buspirone 5 mg twice daily. The next step down could be to have R20 administered Buspirone 2.5 mg twice daily, however his anxiety and agitation seemed to be worsening, so this might not be the best time to try lowering R20's dose. On 06/20/24 the provider disagreed by as he checked off other on MRR and did not provide a rationale. On 10/09/24, the MRR was completed, pharmacist recommend a GDR for Buspirone. R20 had been receiving Buspirone 5 mg twice daily, recommend trying 2.5mg twice a day. On 10/17/24 provider disagreed cited clinical condition. During an interview on 12/11/24 at 08:51 AM, Administrative Nurse B confirmed that R20's 06/11/24 GDR lacked an appropriate response from the physician. During an interview on 12/11/24 at 02:18 PM, Licensed Nurse (LN) U reported the nurse would be responsible to complete the required AIMS assessment quarterly. LN U reported that Administrative Nurse C would communicate with nurses in household when a resident was due for a review of an annual, quarterly, and or significant change MDS and the nurse was required to open the assessments that were required in the EHR and complete them. During an interview on 12/11/24 03:31 PM, Administrative Nurse B reported she expected nurses to complete and AIMS assessment every three months and as needed. She confirmed that R20 had not had an AIMS assessment completed since 08/11/24 and that R62 had no AIMS completed when he received the Seroquel. Furthermore, she expected the pharmacist to complete a thorough chart review and the pharmacist should have addressed the diagnosis rationale for the Seroquel and addressed that no AIMS was completed in a timely manner. The facility's policy Psychotropic Medications Use dated 11/2017, documented the following: Psycho-pharmacologic medications are drugs that affect the brain activities associated with mental health processes and behaviors. Psychotropic medications are divided into four broad categories: antipsychotic, antidepressant, antianxiety and hypnotic medications. Each resident's drug regimen must be free from unnecessary drugs, which included without adequate indication and without adequate monitoring. The physicians order for a psychotropic medication would include both a qualifying diagnosis and a list of specific target behaviors for staff to monitor. (continued on next page)

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	17E546	A. Building B. Wing	12/12/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to prevent the use of unnecessary medications for R20 when the facility failed to respond appropriately to pharmacist recommendation for GDR. The facility failed to address the appropriate diagnosis for antipsychotic medication for R20. Additionally, the facility failed to complete the AIMS assessments for R20 and R62. These deficient practices had the potential to lead to uncommunicated needs which could lead to negative impacts on the resident's physical, mental and psychosocial well-being.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50659 The facility had a census of 73 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to ensure two of the four households observed and reviewed during the medication administration pass remained free of medication errors. Forty-two medication opportunities were observed with fifteen medication errors identified This placed the residents at risk for adverse reactions from the medications and resulted in a medication error rate of 35.71%. Findings Included: R65's Physician Orders included for staff to flush the resident's Percutaneous Endoscopic Gastrostomy tube (PEG-tube surgically placed through an artificial opening into the stomach) with 150 milliliters (ml) of water before and after administration of medications, date ordered 11/14/24. - During an observation on 12/10/24 at 10:36 AM, Licensed Nurse (LN) Z prepared Resident (R) 65's medications, which included Gabapentin (anticonvulsant medication) and Acetaminophen-Codeine (pain medication). Both medications were crushed separately and placed into separate medication cups. LN Z poured 90 ml of water into a separate cup. Then she poured a small amount of the 90 ml of water into another cup and poured both medications into the smaller cup of water. LN Z then checked placement of the resident's peg tube, administered a small amount of water through a syringe, administered the mixed medications through R65's peg tube, and flushed the peg tube with remainder of the water that totaled 90 milliliters of water. During an interview on 12/10/24 at 12:26 PM, LN Z reported she would use less water than was ordered as R65 could get nauseous. LN Z reported she had always mixed R65s medications together in water before administration. During an interview on 12/11/24 at 10:29 AM, Consultant Staff Y reported R65 should receive the correct water flushes that were ordered by the resident's provider as that amount was included in the resident's daily intake requirements. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B reported that she expected the nurse to administer the correct amount of water ordered and not to mix medications unless ordered by a physician. for R65. - During an observation on 12/12/24 at 07:27 AM, LN U prepared R67's medications at R67's doorway of room and included the following medications: Losartan (a medication used to treat high blood pressure) 100 mg tablet, give one tablet by mouth daily, for hypertension (high blood pressure), date ordered 06/22/23. Miralax (used to treat constipation) give 17 grams by mouth daily for constipation, date ordered 06/22/23. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prednisone (corticosteroid medicine used to decrease inflammation and keep the immune system in check) five mg tablet, give one tablet by mouth three times a day for cancer, date ordered 06/22/23. Medication was not administered as it was not available. Vitamin D 50 microgram (mcg), capsule, give one capsule daily by mouth, for vitamin d deficiency, date ordered 06/22/23. Vitamin B-12 100 mcg, give two tablets by mouth daily, for deficiency, date ordered 06/23/23. Cranberry Concentrate 30,000 mg plus Vitamin C capsule, give one capsule by mouth daily, for cancer, date ordered 06/23/23. Colace (medication treats occasional constipation) 100 mg capsule, give one capsule by mouth daily, for constipation, date ordered 07/31/23. Metoprolol Succinate (a medication used to treat high blood pressure) 200 mg tablet by mouth daily, for hypertension, date ordered 10/17/23. The medication was ordered as an extended release 24 hour tablet, which was not what was administered. Oyster Shell Calcium (used to prevent or to treat a calcium deficiency) 500 mg Vitamin D3 tablet, give one tablet daily, for health maintenance. Administer with a full glass of water, or juice one to three hours after meals or other medications, date ordered 02/20/24. Aldactone (a medication used to treat heart failure and high blood pressure) 25 mg tablet, give one tablet by mouth daily for hypertension, date ordered 03/14/24. Sertraline (a medication used for depression) 50mg tablet, give one tablet by mouth daily for depression, date ordered 06/28/24. Eliquis (blood thinner medication) five mg tablet, give one tablet by mouth, two times a day for pulmonary embolism (is a blood clot that blocks and stops blood flow to an artery in the lung), date ordered 07/04/24. Amlodipine (medication used to treat high blood pressure) 10 mg tablet, give one tablet by mouth daily for hypertension, date ordered 09/04/24. LN U left medications in R67's room on table and closed R67's door. During an interview on 12/11/24 at 07:50 AM, LN U reported the resident's Prednisone five mg tablet was not available to administer to R67 since 11/29/24 and statedR67's daughter was aware. LN U reported R67 received his medications from the Veterans Affair Pharmacy and noted the facility has had issues with receiving medications in a timely manner. LN U confirmed R67's Metoprolol Succinate 200 mg tablet in the prescription bottle lacked the extended-release direction on the label as per the provider's order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LN U reported he would leave all of the medications that he had prepared in R67's room while R67 was not in the room and was observed seated at dining room table eating breakfast. LN U reported that R67 requested to have his medications left in his room, with a cup of yogurt. LN U was unsure if R67 had that request on providers orders or addressed on care plan. LN U confirmed that the household did have other residents that were confused and wandered independently and reported that he shut the door to R67's room. Review of R67's Care Plan lacked any documentation regarding self -administration of medications. Review of 67's Electronic Health Record lacked any documentation regarding self -administration of medications. During an interview on 12/12/24 at 11:34 AM, Administrative Nurse B reported that she expected staff to observe all medications that were ordered to be administered and stated they were not to be left in a resident's room, unsupervised. She also expected staff to have the correct medication that was ordered for each resident. The facility's policy Peg Tube Feeding dated 07/23/24 documented the following: Involve the delivery of liquid nutrition directly into the stomach for patients who cannot eat adequately. If a medication must be crushed, dissolve pills well and flush the tube with water after administration of each medication as ordered by physician. The facility's policy Administration of Oral Medications dated 01/01/2017, documented the following: All medications will be administered to every elder as ordered by a physician in a safe and sanitary manner. Check accuracy and completeness of each medication ordered. Do not leave medication on a table in bedroom. If a drug is not available at the scheduled administration times, contact the ordering physician for instructions on how to proceed with order. The facility failed to ensure that R67's medications were administered in a secure environment, correct dosage and available medication. Additionally, the facility failed to administer the correct water flush to R65 and administer the medications correctly. Furthermore, the facility failed to ensure that the overall medication error rate was below 5%. These deficient practices had the potential to have a negative effect on the overall physical and psychosocial well-being of the residents in the facility.

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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 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. 51334 The facility reported a census of 73 residents with 18 residents sampled. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in locked compartments and permitted only authorized personnel to have access to the keys. This deficiency had the potential to affect three of the four households with expired medications for multi person use and unsecured medications in the room of Resident (R)5, R48, R16, and R57. Findings included: - During an observation on 12/09/24 at 08:56 AM, R5 was in her room and a small medication cup, with pills in the cup, was on the table next to her. The resident stated the staff left her pills like this every day and pointed out that the medication cup had one blue, one yellow, one green pill and the rest were nine white pills. She reported she did not know what the medications were for. At 10:20 AM the medication cup and pills were gone and R5 reported she took the medications herself and no staff came back in to check if she took the medications. During an observation on 12/10/24 at 08:15 AM, R48 had two Nystatin powders, one of them had expired on 09/10/24. During an observation on 12/10/24 at 09:34 AM, R16 had saline nasal gel which expired 05/2024, three containers of Refresh classic lubricant classic eye drops, Nystatin powder which expired 04/2022, Nystatin powder which expired 05/2022, Nystatin powder expired 11/2023, Nystatin powder, 'Butt Paste', Corona Cream (skin protectant) labeled for veterinary use only, tea tree oil, salicylic acid 17% (topical medication used to treat skin disorders) expired 11/2023, alcohol and peroxide in medicine cabinet. These medications were again seen in the resident's room on 12/11/24 at 09:35 AM. During an observation on 12/11/24 at 08:57 AM revealed R48 had two Nystatin powders, one of them had expired on 09/10/24. During an observation on 12/12/24 at 07:27 AM, Licensed Nurse (LN) U gathered R 57's medications which included: Aldactone (used to treat heart failure) 25 mg tablet, Amlodipine (medication to relax the blood vessels) 10 mg tablet, Colace (stool softener) 100 mg capsule, Cranberry 30000 with vitamin C, Vitamin B-12 100 mcg two tablets, Eliquis (blood thinner) five mg table, Losartan (treat high blood pressure) 100 mg tablet, Metoprolol SA ER 200 (extended release medication to treat high blood pressure) mg tablet, Miralax (laxative) 17 gm mixed in juice, and Vitamin D3 50 mcg tablet. LN U had to cut Zoloft (antidepressant) 100 mg tablet in half to get the 50 mg dose. The nurse left the keys in the medication room drawer and left it open while he walked away to cut the pill. The drawer was not in his line of sight, when he came back, he realized he left unsecured meds as he pointed it out. He reported that he should have shut and locked the drawer. Then LN U added Oyster Shell 500 mg tablet. LN U left R57's medications in his room with his yogurt per resident's previous request as R57 was seated at his table eating breakfast. They were left in his room on a table, and LN U shut the door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens County Hospital Ltcu Dba Pioneer Manor	1711 S Main Street Hugoton, KS 67951

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/12/24 at 09:43 AM, LN M had narcotic medications for three residents in a pill container in her pocket. It contained both the breakfast narcotics and the dinner narcotics. They were signed out in the narcotic book but did not have the time documented to note when the pills were given. This pill container had each residents' room number written on it but did not identify what the medication or dosage was. During an observation on 12/12/24 at 10:12 AM, the refrigerator in the medication room contained a multi-use bottle of Novolog (a fast-acting insulin to treat high blood sugar), opened on 10/22/24 and was dated to expire on 11/22/24. A cabinet in the medication room had an undated bottle of Miralax with an expiration date of 08/2024. Also, Slow Magnesium opened and undated with an expiration date of 10/2024. Other medications opened and not dated included: Milk of Magnesium, menthol ointment, vitamin D3, cough medication, stool softener, and acetaminophen. During an interview on 12/11/24 at 10:51 AM, Licensed Nurse (LN) M described the process for staff if they find medication in a resident's room. LN M said the staff were to confiscate the medications and bring the medications to the medication room. LN M said R28 had a history of calling her family and friends to bring medications in for her. LN M said there were no residents with the ability to self-administer medications or have possession of medications on the meadowlark unit. LN M stated the nurse should have them locked and the residents were only to take the medications provided by the nurse. During an interview on 12/11/24 at 02:31 PM, LN U confirmed the staff normally left the wound care medications and supplies by the window on the dresser (in the resident's room). During an interview on 12/12/24 at 07:27 AM, Licensed Nurse (LN) U reported he left R57's medications in his room with his yogurt per the resident's previous request as R57 was seated at his table eating breakfast. LN U reported he was not sure if the resident was care planned for this and verified he did shut his door and the medications were left in his room on a table. After, LN U reported there were wandering residents in the house/unit, but stated he did shut the door. During an interview on 12/12/24 at 09:43 AM, LN M admitted she signed out the narcotic medications at the beginning of the shift and carried the narcotics for three residents in a pill container in her pocket. It contained narcotics for the morning and evening doses. She stated she signed out the medications in the narcotic book but did not put the time the pills were administered until after it was given. The pill container had the residents' room number, but not the medication name or the dose. During an interview on 12/12/24 at 10:12 AM, LN BB revealed the Novolog should be thrown out after 28 days and stated all medications must be labeled and dated. LN BB said the staff did not usually use the medications that were in the cabinet. LN BB said when staff opened a medication, they put the medication in the appropriate resident's room with a date it was opened. LN BB said they only occasionally used those medications, so they got forgot. During an interview on 12/12/24 at 11:14 AM, Administrative Nurse A and Administrative Nurse B agreed unsecured medications located in a residents' rooms was not appropriate. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy Medication Storage dated 08/2017 documented that only licensed nurses, consultant pharmacists, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies ate licked, Controlled medications are stored separately from other medications in a locked drawer. Scheduled II medication were to be stored under double locks. Outdated medications were to be immediately disposed of. The facility's policy Administration of Oral Medication dated 08/2017 documented staff were to prepare one resident's medication and give to them before going to another resident. Observe the resident take the medications. Do not leave medications on a table. The facility failed to ensure drugs and biologicals used in the facility were labeled and stored in locked compartments and permitted only authorized personnel to have access to the keys. This deficiency had the potential to affect three of the four households with expired medications in for multi person use and unsecured medications in the room of R5, R48, R16, and R57.

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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. 51334 The facility reported a census of 73 residents. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program (IPCP) to provide a safe and sanitary environment for all residents through the following: The facility failed to ensure an effective infection control surveillance program regarding the tracking of infections of Resident (R)12 and R48. The facility failed to ensure staff performed hand hygiene prior to and during care for R20, R27, and R14. The facility failed to ensure the implementation of enhanced barrier precautions (EBP - a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms [MDROs] in nursing homes) when providing wound care for Resident (R) 24, R14, R27, and R20. These deficient practices had the potential to affect all residents in the facility. Findings included: - During an observation on 12/10/24 at 08:46 AM, Certified Nurse Aide (CNA) S mixed medicated creams in her gloved hand after Licensed Nurse (LN) T told her those were the creams to use. R14 was positioned on his right and his buttock was extremely red with several open areas noted on the left buttock. CNA S applied the cream and assisted R14 to lay on his back. CNA S removed a disposable wash wipe from the package with the same gloves on that she used to apply the cream on R14's buttock moments earlier and proceeded to wash R14's peri area. The wipe had some bowel movement on the wipe from R14's groin area. CNA S discarded the wipe and CMA V gave her a new wipe, that was used to wipe repeatedly on R14's scrotum in an upward motion towards his penis. CNA S discarded the wipe, CMA V provided a new wipe, and CNA S made several more upward motions, wiping towards R14's penis. Licensed Nurse (LN) T came back into the room with gloves on and an ABD pad (large pad to absorb drainage) and applied a plain ABD pad to the open areas on R14's right buttock, which had fresh bleeding from the areas. LN T removed her gloves, washed her hands, and left the room. CNA S removed her gloves and applied new gloves without hand washing. Then she removed more cream from containers of Zinc and Triamcinolone cream and applied the cream to R14's groin area. Then the aides removed their gloves and washed their hands. During observation on 12/10/24 at 10:21 AM, Licensed Nurse (LN) H and CNA I applied personal protective equipment (PPE) with no handwashing noted. LN H set up the dressing change supplies on the over bed table with no barrier under the supplies. LN H shut the call light off with her gloved hand, removed the dressing from R27, and cleansed the area. LN H sprayed the wound directly with wound cleanser even though some of the 4x4 had been sprayed when prepping supplies and placed the wound cleanser bottle on-top of some of the personal belongings on the resident's bedside tray table. LN H applied Medi honey (medical grade honey used to aid wound healing) with a cotton tip to the open slit on the sacrum, then picked up the medi-honey tube and applied some to a plain packing strip and placed that into the sacral slit with her gloved finger. LN H applied the cream around the reddened area. LN H removed her gloves and applied new gloves without performing hand hygiene. LN H then covered the area with an ABD pad (large pad to absorb drainage) and assisted R27 with applying her briefs and repositioned her in bed. LN H then removed the dressing supplies from the bed side tray table, placed them on the moveable nurse cart with her computer, gave the resident her medication, and then washed her hands. Then LN H place the wound care supplies in a box that is next to R27's television. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/11/24 at 09:46 AM, Certified Nurse Aide (CNA) E pushed R20 in his geri chair into his room, with a blanket over his lap that drug on the ground. CNA F assist CNA E to transfer him. They donned gloves but did not perform hand hygiene. LN G donned gloves with hand hygiene, and then provided peri-care, cleaning bowel movement with wipes that were folded then used to wipe again. CNA E retrieved the zinc cream from the cabinet and new brief without changing gloves or performing hand hygiene, and then applied barrier cream. CNA E then changed gloves without performing hand hygiene. CNA F placed barrier cream on R20's genitals/inguinal folds without changing gloves or performing hand hygiene. The CNA doffed her gloves and returned the wipes and zinc cream to the cabinet without performing hand hygiene. During an observation on 12/12/24 at 09:50 AM, LN BB provided a dressing change to R24. She wore gloves, but no gown and placed a fresh dressing following the new orders she received. LN BB reported the staff did not use enhanced barrier precautions for open wounds. During an interview on 12/10/24 at 10:50 AM, LN H was asked if she would have done anything different with how treatment was performed on R27, she said no. The surveyor reviewed with LN H that the supplies were set up without a barrier and handled with no handwashing, no hand washing at the beginning when PPE was applied, and no handwashing when gloves were removed, and new gloves applied. Reminded LN H the area was cleansed, without removing gloves after removal of soiled dressing and she had shut off the call light with her gloved hand, cleansed the area over and over with same 4x4 and used the wound cleanser and placed it on personal belongings on the tray table. LN H removed her gloves and then had administered medications to the resident, and placed all the wound supplies on her cart, before she washed her hands. LN H confirmed she was nervous, and she should have washed hands and removed gloves appropriately and wash hands. She also reported she should have cleaned the tray table off, set up a barrier for the supplies, and she should have cleaned the scissors before and after she used them, and left the box of wound supplies in the R27s room. During an interview on 12/10/24 at 11:00 AM, CNA I said she would not have done anything different when applying PPE outside the resident's room CNA I reported she washed her hands prior to coming to the resident's room and confirmed she did not use the hand sanitizer on the cart before applying the gloves, even though she had to open the drawers on cart to get out the gown. During an interview on 12/11/24 at 02:31 PM, LN U confirmed the facility had an EBP policy and R14 should be on it but stated R14 was not on EBP. During an interview on 12/11/24 at 02:34 PM, LN acknowledged she did not use EBP during the dressing change on R20. During an interview on 12/11/24 at 10:16 AM, CNA E and CNA F stated they were not allowed to use resident's sink to wash hands and they must use the sink in the main area. CNA E and CNA F confirmed they did not perform hand hygiene before starting or between phases. During an interview on 12/11/24 at 03:31 PM, Administrative Nurse B stated she did not realize R14 had an open wound and confirmed that residents with open areas should be on EBP. During an interview on 12/12/24 at 09:50 AM, LN BB confirmed that R24 had an open pressure ulcer on her back but did not believe she needed a gown to treat it. She believed they only required EBP for catheters. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/12/24 at 10:50 AM with Administrative Nurse B, it was revealed that the nurses on the unit complete the surveillance logs. During review of the logs, Administrative Nurse B acknowledged R48 had no culture for a 12/10/24 infection even though the logs show it was completed, and R12 had no culture available for infection on 9/26/24, even though the log reported she had one done. The Infection Control Surveillance Logs lacked a causative organism, site of infection, some documented a culture but lacked the documentation, and lacked mapping. Administrative Nurse B acknowledged it was an ineffective infection control program. The facility's Enhanced Barrier Precautions policy dated 06/25/24 revealed an order for EBP would be obtained for any resident that had an open wound when staff are providing high contact care. These cares included dressing, bathing, transferring, providing hygiene, changing linens, toileting, incontinence care, caring for a device (catheters and feeding tubes), and wound care. The facility's Infection Control Policy dated 12/28/24 revealed the infection control program would include surveillance and investigation. The IP Nurse is responsible for overseeing the infection control program. Surveillance was to include the sight of the infection, cultures, and the result, organism identified by the culture, antibiotic ordered, review of the sensitivity with report, and a monthly analysis of tracking and trending. The facility failed to ensure an effective infection control surveillance program regarding the tracking of infections of Resident (R)12 and R48. The facility failed to ensure staff performed hand hygiene prior to and during care for R20, R27, and R14. The facility failed to ensure the implementation of enhanced barrier precautions (EBP - a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms [MDROs] in nursing homes) when providing wound care for Resident (R) 24, R14, R27, and R20. These deficient practices had the potential to affect all 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. 51334 The facility reported a census of 73 residents. Based on interview and record review the facility failed to implement an effective antibiotic stewardship program that included antibiotic use protocols, an effective system to monitor antibiotic use, and/or an effective system to track and trend infections in the building for the facility's Infection Prevention and Control Program (IPCP). This failure had the potential to affect all 73 residents. Findings included: - During an interview on 12/12/24 at 10:50 AM, Administrative Staff B revealed the facility did not have an effective infection control program, which included an Antibiotic Stewardship Program. The staff that completed the Infection Control Surveillance Logs were not trained in infection control or Antibiotic Stewardship. Administrative Staff B stated she was the Infection Preventionist, but the floor nurses were completing the Infection Control Surveillance Logs. Administrative Nurse B acknowledged the logs lacked a causative organism, site of infection, some documented a culture but lacked further documentation and lacked mapping of infections in the facility. She stated she tried to enforce the McGeer criteria (a set of surveillance definitions for infections in long-term care facilities) for documenting the appropriateness of antibiotics but acknowledged more education needed to be provided to staff. She stated that the pharmacy helped with the infection control program some. Administrative Nurse B would talk to the doctor about antibiotic orders and the use of prophylactic antibiotics, but they had a resident physician who believed in medicating with prophylactic antibiotics after a resident had two urinary tract infections and noted that did not follow the Antibiotic Stewardship Guidelines. The facility policy Pioneer Manor Antibiotic Stewardship Program dated 12/28/17 revealed the mission is to provide the best antimicrobial therapy (right dose, right drug, right durations) for the best outcome to the residents. They were to establish an Antibiotic Stewardship Program (ASP) team that would review the infections and monitor antibiotic usage patterns monthly and make a separate report of the number of residents on antibiotics that did not meet the criteria for an infection. The IP Nurse was responsible for the infection surveillance and MDRO tracking. Repeated and regular education will be provided for clinical staff as well as residents and their families on appropriate use of antibiotics. The facility failed to implement an effective antibiotic stewardship program that included antibiotic use protocols, an effective system to monitor antibiotic use, and/or an effective system to track and trend infections in the building for the facility's Infection Prevention and Control Program (IPCP). This failure had the potential to affect all 73 residents.

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	17E546	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 51334 The facility reported a census of 73 residents. Based on interview and record review the facility failed to ensure the Infection Preventionist (IP) assessed, implemented, and monitored the facility Infection Prevention and Control Program (IPCP). This failure has the potential to affect all 73 residents. Findings included: - During an interview on 12/12/24 at 10:50 AM, Administrative Staff B revealed the facility did not have an effective IPCP. Administrative Staff B verified she was the IP, but the floor nurses completed the Infection Control Surveillance Logs. As Administrative Staff B reviewed the Infection Control Surveillance Logs, she acknowledged the logs lacked a causative organism, site of infection, some documented a culture but lacked the documentation, and the log lacked mapping (for tracking and trending). Administrative Staff B stated the nurses were not trained in infection control or Antibiotic Stewardship and acknowledged the nurses needed infection control training. The facility's Infection Control Policy dated 12/28/24 revealed the infection control program would include surveillance and investigation. The IP Nurse is responsible for overseeing the infection control program including, but not limited to surveillance of infections and tracking and trending infections in the facility. Surveillance was to include the sight of the infection, cultures, and the result, organism identified by the culture, antibiotic ordered, review of the sensitivity with report, and a monthly analysis of tracking and trending. The facility failed to ensure the Infection Preventionist (IP) assessed, implemented, and monitored the facility Infection Prevention and Control Program (IPCP). This failure had the potential to affect all 73 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. 51334 The facility reported a census of 73 residents with 18 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)) or the consent/declination form to Resident (R) 65 and R27. The facility further failed to provide the influenza (highly contagious viral infection) vaccine or the consent/declination form to R65, R27, and R240 and failed to complete and document an assessment prior to giving the influenza vaccine to R48. Findings included: - Review of the Electronic Health Record (EHR) for R65 and R27 lacked documentation the facility had a signed pneumococcal vaccine declination form. The EHR lacked historical documentation, which included the resident's pneumococcal vaccine immunization record. Review of the EHR for 2024 for R65, R27, and R24 lacked documentation the facility provided the residents with any form, which documented their consent/declination of the influenza vaccine. Additionally, R48's record lacked documentation of an assessment prior to receiving the vaccination. During an interview on 12/12/24 at 10:50 AM Administrative Nurse B confirmed R65 and R27 lacked the consent/declination form and/or immunization record, which showed the pneumococcal vaccine was offered and/or administered in the past. Administrative Nurse B also confirmed R65, R27, and R24 lacked the consent/declination form and/or immunization record stating that the influenza vaccine was offered by the facility and/or administered elsewhere. She further confirmed R48's EHR lacked documentation of a nursing assessment prior to administering the vaccine and acknowledged that was a requirement prior to administration. The facility's Immunization Policy dated 08/2017, documents all residents will be offered the influenza vaccine annually and all new admissions will be offered the pneumonia vaccine. The policy stated resident's temperature will be taken prior to administration. The facility failed to provide the pneumococcal vaccine or the consent/declination form to Resident (R) 65 and R27. The facility further failed to provide the influenza (highly contagious viral infection) vaccine or the consent/declination form to R65, R27, and R240 and failed to complete and document an assessment prior to giving the influenza vaccine to R48.

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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. 50659 The facility reported a census of 73 residents. Five Certified Nurse Aide (CNA) staff, who worked in the facility over a year, were reviewed for required annual in-service training. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for Certified Nurse Aide (CNAs) with the required topics and no less than 12 hours per year. Two CNA staff lacked the required training topics, and one CNA lacked the required 12 hours per year of in-service training. Findings included: - On 12/12/24 at 09:56 AM, review of training records for five CNAs employed by the facility for more than one year revealed one CNA had less than 12 hours of documented in-service training for the previous 12 months. CNA FF had eight hours and twelve minutes of documented training. On 12/12/24 at 09:56 AM, review of training records for five CNAs employed by the facility for more than one year revealed two CNAs did not have the required topics for in-service training for the previous 12 months. CNA FF and CNA GG lacked dementia care training. On 12/12/24 at 10:29 AM, Administrative Staff A reported she would talk to Administrative Nurse B to confirm if she had any more records for the education hours and topics for the five CNAs sampled. Additionally, she reported she would contact the on-line program also to verify more hours and educations topics. Administrative Staff A reported the educational topic feeding dementia patients noted in the CNAs education packet was not the full dementia training. On 12/12/24 at 02:00 PM, 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 CNA FF. Additionally, Administrative Staff A confirmed the annual dementia training was not noted on two of the CNA's recorded hours and topics of education and she reported that was a concern. The facility did not provide a policy related to CNA continuing education and in-service training as requested on 12/12/24. The facility failed to develop, implement and permanently maintain an in-service training program for CNAs with the required topics and no less than 12 in-service training hours per year.