STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E625	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ness County Hospital Ltcu Dba Cedar Village	312 Custer Street Ness City, KS 67560

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 22 residents. The sample included 12 residents, with one reviewed for dignity. Based on observation, record review, and interview, the facility failed to promote dignity for one resident, Resident (R) 22, whose pajamas were soiled with urine from her waist down to the back of her knees. The facility further failed to promote dignity for R22 by taking her out into the common area and into an activity in her pajamas. This placed the resident at risk for impaired dignity. - The Electronic Medical Record (EMR) for R22 documented diagnoses of pressure ulcers, dementia (a progressive mental disorder characterized by failing memory and confusion), acute kidney failure (the kidney suddenly can't filter waste from the blood), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), vitamin deficiency (a deficiency of one or more essential vitamins), and pain. The Significant Change Minimum Data Set (MDS), dated [DATE], documented R22 had severely impaired cognition. R22 was dependent upon staff for transfers and toileting hygiene. R22 required substantial assistance with dressing and lower functional impairment on both sides. The MDS documented R22 was frequently incontinent of bladder and occasionally incontinent of bowel. The Quarterly MDS, dated [DATE], documented R22 had severely impaired cognition. R22 required substantial assistance from staff for toileting hygiene, lower body dressing, and toileting, and had lower functional impairment on both sides. The MDS documented R22 was frequently incontinent of bladder and bowel. R22's Care Plan, dated 02/25/25, initiated on 11/05/24, directed staff to assist R22 with all activities of daily living (ADL). The care plan directed staff to allow her to do as much for herself as possible and assist her with personal hygiene. The care plan update, dated 12/31/24, directed staff to toilet her approximately every two hours. (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: 17E625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER: Ness County Hospital Ltcu Dba Cedar Village		STREET ADDRESS, CITY, STATE, ZIP CODE: 312 Custer Street Ness City, KS 67560	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 09:55 AM, R22 was in bed and had bilateral heel protectors on. CNA N removed the heel protectors and swung her legs over the side of the bed. R22 did not have any socks on, and her bare feet were placed on the footplate of the sit-to-stand mechanical lift. CNA B placed the sit-to-stand sling around the resident, attached it to the lift, and R22 was lifted to a standing position. R22's bed had a chuck (a disposable bed pad used to protect bedding or furniture from urinary incontinence) that was heavily soiled with urine. R22's back of her pajama pants was soiled with urine clear down to the back of her knees. When asked, Certified Nurse Aide (CNA) P stated R22 had been last toileted at 07:00 AM. R22 stated, I'm cold. CNA N stated, Don't worry, you're going to get a bath today. CNA N put a clean brief on R22 and clean pajama pants on, left her pajama top on, and socks. CNA N did not put R22's pressure-relieving boots back on. CNA N stated she was not sure how R22 obtained the pressure ulcer but thought it was from pushing on the footboard on her bed, and it just did not heal. R22 was pushed into the area by the nurse's station and CNA N stated, You didn't have breakfast, I will get you a Danish. At 10:34 AM, R22 was still out in the commons area, in pajamas, and no pressure-relieving boots. Activity staff asked R22 if she wanted to participate in the music activity and told her to lift her feet up so she could push her into the activity room. R22 lifted her toes up but her heels were dragging on the floor, and she lacked any protection on her feet. At 11:45 AM, when asked, R22 stated she had got to sleep in but was not dressed. At 12:00 PM, the Nursing Staff came into the activity room and stated, It's time for lunch and R22 stated, But I am not dressed. As R22 was taken to her room. CNA N stated, It's time for lunch, where is she going? CNA N was told that R22 was not dressed, and she did not want to go to lunch without being dressed. When CNA N was asked why she was not given a bath like R22 was told or had her pajamas covered, CNA N stated, She was supposed to get a bath, but my coworker is lazy. I told her she had to give her a bath right after lunch. R22 returned to the commons area dressed and had her pressure-relieving boots on. On 03/05/25 at 01:00 PM, Administrative Nurse D stated that R22 should not have been taken out into the commons area in her pajamas, but did not speak of why R22 was soaked with urine. The facility's Right to Dignity policy, dated 01/30/20, documented the facility will promote care for residents of the facility in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of the resident's individuality. The facility failed to promote care for R22 in a manner to maintain and enhance dignity and respect. This placed R22 at risk for impaired dignity.

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NAME OF PROVIDER OR SUPPLIER Ness County Hospital Ltcu Dba Cedar Village		STREET ADDRESS, CITY, STATE, ZIP CODE 312 Custer Street Ness City, KS 67560	

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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 - Few	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** 37450 The facility had a census of 22 residents. The sample included 12. Based on observation, record review, and interview, the facility failed to implement effective care plan interventions for Resident (R) 6 from falling and sustaining major injuries. This deficient practice placed R6 at risk for continued falls and injuries. Findings included: - The Electronic Medical Record (EMR) for R6 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypertension (HTN - elevated blood pressure), chronic atrial fibrillation (rapid, irregular heartbeat), fracture (broken bone) of body of sternum (t-shaped bone of front chest) and other parts of the pelvis (bones between the lower abdomen and upper thighs that connect the spine to the legs). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R6 had moderately impaired cognition, and exhibited no behaviors. R6 had functional range of motion impairment to both sides of the lower extremities, was dependent with toileting hygiene, and lower body dressing. R6 required partial/moderate assistance with personal hygiene and substantial/maximal assistance with rolling left and right, and transfers and walking were not attempted. The MDS further documented R6 had one fall with major injury since prior assessment. R6 also had two pressure injuries presenting as deep tissue injuries (DTI - purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear) which were present on readmission to the facility. The Fall Care Area Assessment (CAA), dated 05/08/24, documented R6 fell on [DATE] in her room at 05:12 PM, was taken to the emergency room , and had a fractured pelvis. R6 returned on 04/19/24 to her room in long-term care, ordered to be on bed rest until further notice. The CAA further documented R6 had been independent in her room prior to the fall. The facility conducted another Significant Change MDS with a Fall CAA dated 08/01/24, which documented R6 had falls on 04/09/24, 06/28/24, and 07/10/24. The CAA further documented R6 fell on [DATE], and a new pelvic fracture was present. R6, now declining the restorative program, was noncompliant with staff assistance, had poor safety awareness, several interventions implemented for fall prevention, had moderately impaired cognition but R6 did not follow directions, and had fractures at the base of the third and fourth digit (fingers). R6's Fall Care Plan dated 02/14/25, documented that R6 was at high risk for falling and had an actual fall with major injury. The Care Plan documented R6 no longer wanted to be asked about restorative therapy. The interventions dated 09/30/24 were for physical therapy and were independent in her room, she used a front-wheeled walker in the hallway. On 04/18/24, a grabber was provided. On 11/23/24, floor grip strips were placed on the floor in front of her recliner and R6 wanted to be more independent. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ness County Hospital Ltcu Dba Cedar Village		STREET ADDRESS, CITY, STATE, ZIP CODE 312 Custer Street Ness City, KS 67560	

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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 - Few	Upon review of R6 falls revealed: The Progress Note dated 04/09/24 at 05:12 PM R6 was found in her room, lying on her right side on the floor, with a walker parked against the bathroom door. R6 complained of right hip pain and had a skin tear to the right elbow. R6 was sent to the emergency room . The Incident Summary dated 04/09/24 concluded R6 reached for an item from the floor when she fell . R6 had been admitted to the hospital for treatment. The recommendation made was to provide a reacher (a device used to help grab items from out of reach). The Computerized Tomography Scan (CT-x-ray technique of imaging to create detailed images) of the pelvis report, dated 04/09/24, revealed moderately displaced fractures of the right superior and inferior pubic ramus (a break or crack in the pelvis bones). The Progress Note dated 06/28/24 at 04:06 AM documented R6 found lying on the right side with bleeding noted to the right ring and little fingers. R6 was barefooted and reported she was going to the bathroom. R6 was sent to the emergency room . The Incident Summary dated 06/28/24 documented R6 was sent to the emergency room and received one stitch in both fingers. The recommendation was to remind R6 to call for assistance when getting up and ambulating. On 07/02/24, an X-ray report revealed that the left hand had a nondisplaced fracture at the base of the fourth digit and a questionable non-displaced fracture at the base of the third digit. The Progress Notes dated 07/10/24 at 09:56 AM documented that R6 was heard yelling and found lying on the floor. The note reported R6 had got up on her own. The physician ordered an X-ray of the right hip and pelvis. The Incident Summary dated 07/10/24 documented that R6 was unattended and had gotten up out of her chair, and R6 was given a reacher (a previous intervention) and shown how to use it so she could grab items out of her reach. And that the nursing staff would take the resident to the bathroom one hour after each meal. The CT Scan (X-ray technique of imaging creates detailed images) of the pelvis, dated 07/13/24, reported an acute comminated (bone break into three or more pieces) fracture of the right ischium (part of the hip bone or over the hip bone area), and the base of the inferior pubic ramus. The Progress Note dated 08/28/24 at 04:44 PM documented R6 signed a contract stating the staff/facility was not responsible for any falls. R6 had been educated on using the call light when she needed assistance, using her walker, and wearing appropriate footwear, including gripper socks. R6 had voiced understanding and was agreeable to this. (R6 had moderately impaired cognition). The chair alarm had been discontinued. The Progress Note dated 11/15/24 at 05:37 AM documented R6 was found on the floor in her room. R6 stated she tried going to the bathroom. R6 right forearm was bleeding and bruised, along with points on her hand. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ness County Hospital Ltcu Dba Cedar Village	312 Custer Street Ness City, KS 67560

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Incident Summary dated 11/15/24 documented steri-stips (adhesive wound closures) placed on R6's forearm. The recommendation/action documented staff instructed that R6 was taken to the bathroom within one hour after meals. R6 was provided a reacher due to wanting to be self-sufficient. On 03/05/25 at 09:25 AM, R6 was in her room, standing at the dresser/TV stand, looking through the top drawer. The walker was parked next to the dresser. The call light was fastened to the left armrest of her recliner. On 03/05/25 at 09:30 AM, Certified Nurse Aide (CNA) M stated R6 does what she wants, and staff tried to catch her when she was up to be near her. CNA M reported thst R6 ate most of her meals in her room, but on occasion, she would come out to see the birds in the activity room or walk up and down the halls. On 03/05/25 at 11:00 AM, Licensed Nurse (LN) G reported that R6 was very stubborn and had poor safety awareness. LN G reviewed a document risk assessment that R6 had signed a release of responsibility form for injuries related to falls. On 03/05/25 at 01:20 PM, Administrative Nurse E verified that R6 had signed a safety education and release of responsibility form when R6 had moderately impaired cognition. Administrative Nurse E reported that the charge nurses were responsible for new interventions to prevent further falls of residents with each fall. The facility's Comprehensive Person-Centered Care Plan policy, dated 03/2022, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs and is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's conditions change. The facility failed to implement effective care plan interventions for R6 from falling. This deficient practice placed the resident at risk for continued falls and injuries.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 22 residents. The sample included 12 residents, with one reviewed for Activities of Daily Living (ADL). Based on observation, record review, and interview, the facility failed to provide meal assistance for one resident, Resident (R) 19, who required assistance. This placed R22 at risk for further weight loss. Findings included: - The Electronic Medical Record (EMR) for R19 documented diagnoses of hypertensive heart disease (heart issues that develop due to long-term high blood pressure), atrial fibrillation (rapid, irregular heartbeat), retention of urine (lack of ability to urinate and empty the bladder), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set Assessment (MDS), dated [DATE], documented R19 had moderately impaired cognition. R19 required partial assistance from staff for dressing, mobility, transfers, and toileting. R19 was independent with eating. The MDS documented R19 had no chewing or swallowing issues, weighed 138 pounds (lbs.), and had no weight loss or gain. The Nutrition Care Area Assessment (CAA), dated 05/09/24, did not trigger. The Quarterly MDS, dated [DATE], documented R19 had moderately impaired cognition. R19 required partial assistance with dressing, ambulation, and personal hygiene. R19 was independent with eating. R19 had no chewing or swallowing issues weighed 143 lbs. and had no weight loss or gains. R19's Care Plan, dated 02/28/25, initiated on 11/17/23, documented R19 may need assistance and one staff assistance with eating depending upon how he felt that day. The update, dated 02/26/25, directed staff to follow a regular diet as ordered, monitor intake daily, and offer alternate food or a house supplement for intake less than 50%. The care plan directed staff to offer assistance if R19 had trouble unwrapping food and drinks and monitor weight closely for gain or loss. The EMR lacked documentation of how often to weigh R19. R19's Vital Sign Log-Weights recorded the following weights: 01/13/25 146.6 lbs. 01/20/25 148.6 lbs. 01/27/25 148.6 lbs. 02/03/25 146.6 lbs. 02/10/25 142 lbs. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/25/25 134 lbs. 03/03/25 128.9 lbs. (12.07 percent [%] weight loss in 30 days) The Nutrition/Dietary Note dated 02/26/25 documented R19's intake had declined. R19's family member requested staff assist R19 with meals. The note directed staff to offer supplements at meals when he didn't eat or wanted to order alternative food. The CDM would continue to make adjustments as needed and consult the Registered Dietician (RD). The EMR lacked documentation the RD was notified of the continued weight loss. The Medication Administration Record (MAR) dated 02/28/25 directed staff to provide a house supplement as needed. The record lacked documentation that the supplement was provided to R19. The EMR recorded R19 was admitted to Hospice (specialized care that mainly aims to provide comfort and dignity to patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) on 02/27/25 due to hypertensive heart failure. On 03/03/35 at 12:05 PM, R19 was taken by wheelchair to the dining room table for the noon meal. R19 leaned against a small pillow on his right side which caused him to be lower than the table. Dietary staff sat a bowl of jello, a glass of water, and his meal of onion rings, green beans, and chicken on the table. R19 tried to adjust himself to get closer to the table. CDM BB went to the table and asked R19 if she could cut his chicken up for him and he stated, Yes. R19 continued to lean slightly to the right, he was able to eat an onion ring but as he reached for his jello, it was out of his reach. R19's fingertips touched the bowl of jello but he could not get close enough to be able to eat it. R19's tablemate R21 pushed the jello closer to R19, and he attempted to take a bite but was unable to do so. At 12:16 PM, a staff member walked up to the table and stated. Do you need some help? R19 stated, If I am going to eat something, I do. The staff member sat down next to him and assisted him with two bites of food. At 12:25 PM, the staff member got up and left the dining room, and never came back. In the dining room, there were three staff members assisting other residents, two at one table and another at a different table. R19 reached for his water and slid it to the edge of the table, but was unable to pick it up to drink. R19's tablemate R21 picked up R19's water glass and held it up to his mouth so R19 could drink. After he had drank some of his water, he tried to move away from the table, dropped his napkin, and attempted to pick it up, and a staff member saw him reaching for the floor, got up, and picked it up for him. R19 attempted to move away from the table again as his tablemate R21 looked around the dining room for someone to assist R19 and as a staff member walked by he asked her to help R19. On 3/4/25 at 09:00 AM, R19 sat in his recliner in his room. His bedside table had a bowl of cream of wheat and toast. This Surveyor asked him how his breakfast was, and he stated, I haven't tried it yet because I need help, and I cannot reach it. Certified Medication Aide (CMA) R was located at the nursing station and asked if there was staff available to assist R19 with his breakfast meal. CMA R used her communication device to ask for staff to go to his room and assist him. CNA N went into his room and stated, What do you need help with? R19 stated, Everything. CNA N stated, Do I need to sit in here with you? During that interaction, CNA O walked into the room and she and CNA R discussed who was going to sit in the room and assist R19. CNA O sat down next to R19 as he tried to eat, and she looked at her cell phone. R19 was able to receive some assistance with his meal. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 09:26 AM, Administrative Staff D stated, R19 had been ill and in the hospital from 02/03/25 to 02/08/25. Administrative Nurse D verified that he had declined since then and staff should be aware and assist him. On 03/04/25 at 10:00 AM, CNA O stated that R19 had declined recently and stated his daughter usually assisted him with his meals. CNA O further stated that R19 did require more assistance with his care and meals. On 03/04/25 at 02:33 PM, Dietary Staff BB stated she had not notified the RD of R19's weight loss. She had provided nursing staff standing orders that the RD had provided to the facility for residents when there was a weight loss. Dietary Staff BB stated if R19 ate less than 50%, staff were to offer alternative food or a supplement. Dietary Staff document meal intakes and nursing staff are to document the supplement. Dietary Staff BB stated she had planned to notify him the next day of R19's weight loss. Dietary Staff BB stated, if a resident had a 5% weight loss in a month, staff were to provide 6 ounces (oz) of orange juice twice a day, provide med pass (nutritional supplement) 2 oz four times per day, meal fortification, multivitamins with minerals, weekly weights, and document the amount he consumed. Dietary Staff BB stated she was unaware that the nursing staff had not followed the recommendations. On 03/04/25 at 02:50 PM, Administrative Nurse E stated she would look at R19's weight loss recommendations. Administrative Nurse E stated that the dietary staff was responsible for meal intake but was not aware that R19 did not receive the supplement. On 03/05/25 at 09:20 AM, Licensed Nurse (LN) G stated that there was a fax communication to the physician on 02/18/25, that R19 had a decreased appetite but was unable to locate any documentation that he was aware of how much weight R19 had lost. She stated R19 was supposed to get a bottle of Ensure (nutritional supplement) with his meals if he ate less than 50%. LN G stated she was unsure when he had received the supplement or not. LN G stated that R19 was on Hospice services and thought that they were aware of his weight loss. On 03/05/25 at 01:00 PM, Administrative Nurse D stated staff should assist R19 with his meals. The facility's Assisting the Impaired Resident with In-Room Meals policy, dated 09/13, directed staff to ensure that the necessary non-food items are in place on the tray i.e., silverware, special devices, napkins, and straws. Position the resident so his or her head and upper body are as upright as possible, position your chair where it would be convenient for you and the resident. Feed the resident slowly and allow plenty of time between mouthfuls. Encourage the resident to eat all of his meal, but do not force him or her to eat. Document how much of the meal the resident consumes and if the resident participated. Document any changes in the resident's ability to participate with the meal and if the resident had any difficulty feeding himself, chewing, or swallowing. Notify the supervisor if the resident refused the meal or to eat. The facility failed to provide meal assistance for R19, who required assistance. This placed R22 at risk for further weight loss.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 22 residents. The sample included 12 residents, with two 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 observation, record review, and interview, the facility failed to prevent the development of a Stage 3 (full thickness tissue loss) pressure ulcer for one resident, Resident (R) 22 who had edema (swelling resulting from an excessive accumulation of fluid in the body tissues) in her legs. The facility also failed to implement interventions to prevent further breakdown and follow the plan of care to wear pressure-relieving boots at all times. This placed the resident at risk for further breakdown. Findings included: - The Electronic Medical Record (EMR) for R22 documented diagnoses of pressure ulcers, dementia (a progressive mental disorder characterized by failing memory and confusion), acute kidney failure (the kidney suddenly can't filter waste from the blood), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), vitamin deficiency (a deficiency of one or more essential vitamins), and pain. The Significant Change Minimum Data Set (MDS), dated [DATE], documented R22 had severely impaired cognition. R22 was dependent upon staff for transfers, toileting hygiene, and partial assistance from staff for mobility, and lower functional impairment on both sides. The MDS documented R22 was at risk for pressure ulcers, had a deep tissue injury (DTI - purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear), received pressure-ulcer care, and had a pressure device for her bed and chair. The Pressure Ulcer Care Area Assessment (CAA), dated 11/15/24, documented R22's heels were floated whenever she was in bed or her recliner, and gel cushions were in her chairs. R22 has had a significant change in her condition due to acute issues with increased confusion with dementia, urinary tract infections (UTI - an infection in any part of the urinary system), and increased pain in both knees. R22's compression socks were not applied until the heel sore was healed. The Quarterly MDS, dated [DATE], documented R22 had severely impaired cognition. R22 required substantial assistance from staff for toileting hygiene, lower body dressing, and toileting, and had lower functional impairment on both sides. The MDS documented R22 was at risk for pressure ulcers, had one stage 3 pressure ulcer, received pressure ulcer care, and had a pressure device for her bed and chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Care Plan, dated 02/25/25, initiated on 11/18/25, directed staff to administer treatments as ordered and monitor for effectiveness. Float heels when in a reclining chair and bed, new wheelchair pedals on her wheelchair for a better fit, and a gel cushion for her wheelchair. The care plan further directed staff to turn/reposition R22 at least every two hours, more often as she required extensive to total assistance with repositioning R22 and required weekly treatment documentation to include measurement of each area of skin breakdown with width, length, depth, type of tissue and exudate (a mass of cells and fluid that has seeped out of blood vessels or an organ, especially in inflammation (swelling). The update, dated 12/31/24, directed staff to toilet her approximately every two hours. The update, dated 02/26/25, directed staff to have heel protectors on at all times. The Braden Scale Assessment (formal assessment for predicting pressure ulcer risk) dated 10/25/24 documented R22 was not at risk for pressure ulcers. The Braden Scale assessment dated [DATE] documented R22 was at risk for pressure ulcers. The Weekly Skin Evaluation dated 11/26/24 documented R22's right heel measured 4.5 cm x 4.2 cm and had eschar. The left heel measured 0.8 cm x 1.2 cm and was scabbed. The Weekly Skin Evaluation dated 12/24/24 documented R22's right heel measured 2.5 cm x 2 cm. The Weekly Skin Evaluation dated 01/01/25 documented R22 had a right heel pressure ulcer but lacked documentation of the measurement. The Physician's Order dated 11/04/24 directed staff to provide liquaCel (protein supplement). 30 milliliters (ml), by mouth, three times per day, for vitamin deficiency. The Physician's Order dated 11/11/24 directed staff to elevate R22's feet twice per day for edema. The Physician's Order dated 11/14/24 directed staff to administer Lasix (a diuretic [medication to promote the formation and excretion of urine]). 20 milligrams (mg), each morning, compression stockings (stockings that help blood flow back into the heart and reduce pain and swelling), knee high for a minimum of 12 hours per day and lower the footrests on the wheelchair. The Nurse's Note dated 11/14/24 at 09:17 AM documented R22 had a new onset of one plus pitting edema in both of her legs and was on an antibiotic (medication that inhibits the growth of or destroys microorganisms) for a UTI. The Nurse's Note dated 11/18/24 at 10:43 AM documented R18 had pressure sores to bilateral heels. The right heel measured five centimeters (cm) x 4.2 cm, and the left heel measures 0.8 cm x 1.2 cm. Staff were directed to apply betadine (an antiseptic used to treat wounds to prevent bacteria) to both heels twice per day until healed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ness County Hospital Ltcu Dba Cedar Village		STREET ADDRESS, CITY, STATE, ZIP CODE: 312 Custer Street Ness City, KS 67560	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Note dated 11/19/24 at 02:05 PM documented nursing staff were concerned that R22 had a blister on her right heel and now there was an area of eschar (dead tissue) on the heel. The note further documented R22 had recently been admitted and laid in bed quite a bit and that is how the blister formed. There is currently no bogginess (spongy, soft texture) underneath the blister. The eschar was firmly attached to the heel and no cellulitis around the eschar. Nursing staff should apply the Betadine, and keep it dry to prevent infection. Should the area become loose or boggy, then the nursing staff need to notify the physician and the physician would reassess. The Nurse's Note dated 11/25/24 at 12:52 PM documented R22 had an appointment at the wound clinic. The Registered Dietician Nutrition/Dietary Note dated 11/26/24 at 09:05 AM documented R22 was new to the facility and had good food and fluid intake. R22 had skin issues on her right and left heel and received protein for extra wound healing. The note documented he recommended continuing with the plan of care. The Nurse's Note dated 11/28/24 at 08:30 AM documented R22's right heel measured 4.3 cm x 3.5 cm was black/brown in color, intact blister was noted. The left heel measured 2 cm x 1 cm open area, no drainage noted, and the edges were pink. R22's heels floated when laid down and walked to the bathroom with her walker and the assistance of two staff. The Nurse's Note dated 12/05/24 at 03:54 PM documented R22's wound on her right heel started to worsen with ambulation and her exercise program was being adjusted until the wounds healed. The Physician's Order dated 12/05/24 directed staff to apply an Iodoflex (absorbs slough, soft necrotic (dead or dying) tissue, and exudate) dressing and cover with a four-by-four silicone foam dressing, to the right heel until healed. The order was discontinued on 01/22/25. The Nurse's Note dated 12/20/24 at 09:43 AM documented R22 had eschar on her right heel. The area developed as a blister because she used her heels to push herself in bed and then underneath the blister, there was a large area of eschar that continued to improve. The Wound Care Notes dated 12/30/24 documented R22 right heel measured 1.5 cm x 1.7 cm x 0.1 cm and directed staff to wear a gel cushion to the right foot to assist with pressure reduction. The EMR lacked documentation that the order was put into place. The Physician's Order dated 01/15/25 directed staff to wear heel protectors at night and remove in the morning. The Nurse's Notes dated 01/17/25 at 11:05 AM documented R22's right heel measured 1.8 cm x 2 cm x 0.1 cm, small amount of serosanguinous (semi-thick blood-tinged drainage) exudate, and surrounding tissue edema. The Wound Care Notes dated 01/22/25 documented R22's right heel measured two cm x two cm x 0.3 cm, a moderate amount of serosanguinous exudate, and surrounding tissue edema. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Care Report dated 01/29/25 documented R22's right heel had a large callous/ eschar. The wound measured 1.8 cm x 2 cm x 0.1 cm, with serosanguinous exudate, and surrounding tissue edema. The staff was directed to apply Promogran Prisma (a dressing indicated for the management of all wounds healing by secondary intent which are clear of necrotic tissue) to the wound bed, activate with normal saline, cover with a four-by-four silicone dressing, change twice a week with showers and as needed. The Wound Care Report dated 02/05/25 documented R22's right heel measured 1.1 cm x 1.2 cm x 0.3 cm, with a moderate amount of serosanguinous exudate, surrounding tissue had edema. The Wound Care Report dated 02/19/25 documented R33's right heel measured 1.6 cm x 1 cm x 0.3 cm, with a moderate amount of serosanguinous exudate, and surrounding tissue edema. The facility was directed to take a multivitamin out and follow label instructions for dosing. Take Vitamin C, 1000 mg, by mouth, daily. Limit salt and increase protein in the diet. Review of the EMR lacked documentation the above recommendation was implemented. The facility was directed to apply silvercel (a sterile non-woven pad with alginate) to the wound bed and cover it with four-by-four bordered gauze, daily and as needed. The Registered Dietician Nutrition/Dietary Note dated 02/20/25 at 04/45 PM documented R22 had increased protein at meals for wound healing and currently took Liquacel to help with the wound. The RD recommended continuing the plan of care. The Physician's Order dated 02/26/25 directed staff for the heel protectors to stay on night and day to reduce pressure on the heels. On 03/04/25 at 09:55 AM, R22 was in bed and had bilateral heel protectors on. CNA N removed the heel protectors and swung her legs over the side of the bed. R22 did not have any socks on, and her bare feet were placed on the footplate of the sit-to-stand mechanical lift. CNA B placed the sit-to-stand sling around the resident, attached it to the lift, and R22 was lifted to a standing position. R22's bed had a chuck (a disposable bed pad used to protect bedding or furniture from urinary incontinence) that was heavily soiled with urine. R22's back of her pajama pants was soiled with urine clear down to the back of her knees. When asked, Certified Nurse Aide (CNA) P stated R22 had been last toileted at 07:00 AM. R22 stated, I'm cold. CNA N stated, Don't worry, you're going to get a bath today. CNA N put a clean brief on R22 and clean pajama pants on her, left her pajama top on, and socks. CNA N did not put R22's pressure-relieving boots back on. CNA N stated she was not sure how R22 obtained the pressure ulcer but thought it was from pushing on the footboard on her bed, and it just did not heal. R22 was pushed into the area by the nurse's station and CNA N stated, You didn't have breakfast, I will get you a Danish. At 10:34 AM, R22 was still out in the commons area, in pajamas, and no pressure-relieving boots. Activity staff asked R22 if she wanted to participate in the music activity and told her to lift her feet up so she could push her into the activity room. R22 lifted her toes up but her heels were dragging on the floor, and she lacked any protection on her feet. At 11:45 AM, when asked, R22 stated she had got to sleep in but was not dressed. At 12:00 PM, the Nursing Staff came into the activity room and stated, It's time for lunch and R22 stated, But I am not dressed. As R22 was taken to her room. CNA N stated, It's time for lunch, where is she going? CNA N was told that R22 was not dressed, and she did not want to go to lunch without being dressed. When CNA N was asked why she was not given a bath like R22 was told or had her pajamas covered, CNA N stated, She was supposed to get a bath, but my coworker is lazy. I told her she had to give her a bath right after lunch. R22 returned to the commons area dressed and had her pressure-relieving boots on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 03:15 PM, LN G washed her hands, gloved, and placed a dry chuck on the floor in front of R22's recliner. LN G removed the soiled dressing from R22's right heel, removed her gloves, and donned clean gloves. LN G cleansed the right heel wound with normal saline. LN G removed soiled gloves, donned clean gloves and placed silvercel in the wound, covered the wound with a foam dressing over it. LN G stated that R22 required more assistance after she came into the facility. She was unsure how she acquired the wound but R22 had a lot of edema and her shoes were too tight. LN G stated R22 had just recently gotten the bigger pressure relieving boot and R22 would be getting a walking boot so she could participate in physical therapy. LN G stated that R22 should have the pressure-relieving boots on at all times. On 03/05/25 at 01:00 PM, Administrative Nurse D stated she could not speak as to how R22 obtained the pressure ulcer. She stated she did not know why it took two months for R22 to have pressure-relieving boots or why interventions were not put into place. Administrative Nurse D stated, that R22 should not have been taken out into the commons area in her pajamas and should have had on her boots. The facility's Wound/Pressure Ulcer Management policy, dated 07/19, documented the facility was committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being. The facility was committed to minimizing the development of in-house acquired pressure ulcers unless the individual's clinical condition demonstrated they were unavoidable. Any resident with a wound received treatment and services consistent with the resident's goal of treatment. Typically, the goal is one of promoting healing and preventing infection unless a resident's preferences and medical condition necessitate palliative care as the primary focus. The facility failed to prevent the development of a Stage 3 for R22 who had edema in her legs. The facility also failed to implement interventions to prevent further breakdown and follow the plan of care to wear pressure-relieving boots at all times. This placed the resident at risk for further breakdown.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 37450 The facility had a census of 22 residents. The sample included 12 residents of which five residents were reviewed for falls. Based on observation, record review, and interview, the facility failed to prevent Resident (R) 6 from falling and sustaining major injuries with ineffective interventions. This placed R6 risk for continued falls and injuries. Findings included: - The Electronic Medical Record (EMR) for R6 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypertension (HTN - elevated blood pressure), chronic atrial fibrillation (rapid, irregular heartbeat), fracture (broken bone) of body of sternum (t-shaped bone of front chest) and other parts of the pelvis (bones between the lower abdomen and upper thighs that connect the spine to the legs). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R6 had moderately impaired cognition, and exhibited no behaviors. R6 had functional range of motion impairment to both sides of the lower extremities, was dependent with toileting hygiene, lower body dressing, required partial/moderate assistance with personal hygiene and substantial/maximal assistance with rolling left and right, and transfers and walking was not attempted. The MDS further documented R6 had one fall with major injury since prior assessment. R6 also had two pressure injuries presenting as deep tissue injuries (DTI- purple or maroon localized area of discolored intact skin or blood?filled blister due to damage of underlying soft tissue from pressure and/or shear) which were present on readmission to the facility. The Fall Care Area Assessment (CAA), dated 05/08/24, documented R6 fell on [DATE] in her room at 05:12 PM, taken to the emergency room and had fractured pelvis. R6 returned on 04/19/24 to her room in long term care, ordered to be on bed rest until further notice. The CAA further documented R6 had been independent in her room prior to the fall. The facility conducted another Significant Change MDS with a Fall CAA dated 08/01/24, which documented R6 had falls on 04/09/24, 06/28/24, and 07/10/24. The CAA further documented R6 fell on [DATE], and a new pelvic fracture was present. R6, now declining the restorative program, was noncompliant with staff assistance, had poor safety awareness, several interventions implemented for fall prevention, had moderately impaired cognition but R6 did not follow directions, and fractures at the base of the third and fourth digit (fingers). The Fall Care Plan dated 02/14/25, documented that R6 was high risk for falling and had an actual fall with major injury. The Care Plan documented R6 no longer wanted to be asked about restorative therapy. The interventions dated 09/30/24 were for physical therapy and were independent in her room, she used a front-wheeled walker in the hallway. On 04/18/24, a grabber was provided. On 11/23/24, floor grip strips were placed on the floor in front of her recliner and R6 wanted to be more independent. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon review of R6 falls revealed: The Progress Note dated 04/09/24 at 05:12 PM R6 was found in her room, lying on her right side on the floor, with a walker parked against the bathroom door. R6 complained of right hip pain and had a skin tear to the right elbow. R6 was sent to the emergency room . The Incident Summary dated 04/09/24 concluded R6 reached for an item from the floor when she fell . R6 had been admitted to the hospital for treatment. The recommendation made was to provide a reacher (device used to help grab items from out of reach). The computerized tomography scan (CT-x-ray technique of imaging to create detailed images) of pelvis report, dated 04/09/24, revealed moderately displaced fractures of the right superior and inferior pubic ramus (a break or crack in the pelvis bones). The Progress Note dated 06/28/24 at 04:06 AM documented R6 found lying on the right side with bleeding noted to the right ring and little fingers, R6 was barefooted and reported she was going to the bathroom. R6 was sent to the emergency room . The Incident Summary dated 06/28/24 documented R6 was sent to the emergency room and received one stitch in both fingers. The recommendation was to remind R6 to call for assistance when getting up and ambulating. On 07/02/24, an X-ray report revealed that the left hand had a nondisplaced fracture at the base of the fourth digit and a questionable non-displaced fracture at the base of the third digit. The Progress Notes dated 07/10/24 at 09:56 AM documented that R6 was heard yelling and found lying on the floor. The note reported R6 had got up on her own. The physician ordered X-ray of the right hip and pelvis. The Incident Summary dated 07/10/24 documented that R6 was unattended and had gotten up out of her chair, and R6 was given a reacher (previous intervention) and shown how to use it so she could grab items out of her reach. And that the nursing staff would take the resident to the bathroom one hour after each meal. The CT-(x-ray technique of imaging creates detailed images) of pelvis, dated 07/13/24, reported an acute comminated (bone break into three or more pieces) fracture of the right ischium (part of the hip bone or over the hip bone area), and the base of the inferior pubic ramus. The Progress Note dated 08/28/24 at 04:44 PM documented R6 signed a contract stating the staff/facility was not responsible for any falls. R6 had been educated on using the call light when she needed assistance, using her walker, and wearing appropriate footwear, including gripper socks. R6 had voiced understood and was agreeable to this. (R6 had moderately impaired cognition). The chair alarm had been discontinued. The Progress Note dated 11/15/24 at 05:37 AM documented R6 was found on the floor in her room. R6 stated she tried going to the bathroom. R6 right forearm was bleeding and bruised, along with points on her hand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Incident Summary dated 11/15/24 documented steri-stips (adhesive wound closures) placed on R6's forearm. The recommendation/action documented staff instructed that R6 was taken to the bathroom within one hour after meals. R6 was provided a reacher due to wanting to be self-sufficient. On 03/05/25 at 09:25 AM, R6 was in her room, standing at the dresser/TV stand, looking through the top drawer. The walker was parked next to the dresser. The call light was fastened to the left armrest of her recliner. On 03/05/25 at 09:30 AM, Certified Nurse Aide (CNA) M stated R6 does what she wants, and staff tries to catch her when she is up to be near her. CNA M reported R6 ate most of her meals in her room, but on occasion she will come out to see the birds in the activity room or walk up and down the halls. On 03/05/25 at 11:00 AM, Licensed Nurse (LN) G reported R6 was very stubborn and had poor safety awareness. LN G reviewed a document risk assessment that R6 had signed a release of responsibility form for injuries related to falls. On 03/05/25 at 01:20 PM, Administrative Nurse E verified R6 had signed a safety education and release of responsibility form when R6 had moderately impaired cognition. Administrative Nurse E reported that the charge nurses were responsible for new interventions to prevent further falls of residents with each fall. The facility's Safety and Supervision of Residents policy, dated 07/2017, documented that the facility strived to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. The individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices and monitoring the effectiveness of interventions. Resident supervision is a core component of the systems approach to safety. The facility failed to prevent R6's falls, which resulted in pelvic and finger fractures with ineffective repeated intervention. This placed the resident at risk for continued falls and injuries.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 22 residents. The sample included 12 residents, with five residents reviewed for falls. Based on observation, record review, and interview, the facility failed to prevent Resident (R) 6 from falling and sustaining major injuries with ineffective interventions. This deficient practice placed R6 at risk for continued falls and injuries. Findings included: - The Electronic Medical Record (EMR) for R6 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypertension (HTN - elevated blood pressure), chronic atrial fibrillation (rapid, irregular heartbeat), fracture (broken bone) of body of sternum (t-shaped bone of front chest), and other parts of the pelvis (bones between the lower abdomen and upper thighs that connect the spine to the legs). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R6 had moderately impaired cognition, and exhibited no behaviors. R6 had a functional range of motion impairment to both sides of the lower extremities and was dependent with toileting hygiene, and lower body dressing. R6 required partial/moderate assistance with personal hygiene and substantial/maximal assistance with rolling left and right, and transfers and walking wwerenot attempted. The MDS further documented R6 had one fall with major injury since the prior assessment. R6 also had two pressure injuries presenting as deep tissue injuries (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) which were present on readmission to the facility. The Fall Care Area Assessment (CAA), dated 05/08/24, documented R6 fell on [DATE] in her room at 05:12 PM, was taken to the emergency room , and had a fractured pelvis. R6 returned on 04/19/24 to her room in long-term care, ordered to be on bed rest until further notice. The CAA further documented R6 had been independent in her room prior to the fall. The facility conducted another Significant Change MDS with a Fall CAA dated 08/01/24, which documented R6 had falls on 04/09/24, 06/28/24, and 07/10/24. The CAA further documented R6 fell on [DATE], and a new pelvic fracture was present. R6, now declining the restorative program, was noncompliant with staff assistance, had poor safety awareness, several interventions implemented for fall prevention, had moderately impaired cognition but R6 did not follow directions, and had fractures at the base of the third and fourth digit (fingers). R6's Fall Care Plan dated 02/14/25 documented that R6 was at high risk for falling and had an actual fall with major injury. The Care Plan documented R6 no longer wanted to be asked about restorative therapy. The interventions dated 09/30/24 were for physical therapy and R6 was independent in her room, she used a front-wheeled walker in the hallway. On 04/18/24, a grabber was provided. On 11/23/24, floor grip strips were placed on the floor in front of her recliner and R6 wanted to be more independent. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon review of R6 falls revealed: The Progress Note dated 04/09/24 at 05:12 PM R6 was found in her room, lying on her right side on the floor, with a walker parked against the bathroom door. R6 complained of right hip pain and had a skin tear to the right elbow. R6 was sent to the emergency room . The Incident Summary dated 04/09/24 concluded R6 reached for an item from the floor when she fell . R6 had been admitted to the hospital for treatment. The recommendation made was to provide a reacher (a device used to help grab items from out of reach). The computerized Tomography Scan (CT-x-ray technique of imaging to create detailed images) of the pelvis report, dated 04/09/24, revealed moderately displaced fractures of the right superior and inferior pubic ramus (a break or crack in the pelvis bones). The Progress Note dated 06/28/24 at 04:06 AM documented R6 found lying on the right side with bleeding noted to the right ring and little fingers, R6 was barefooted and reported she was going to the bathroom. R6 was sent to the emergency room . The Incident Summary dated 06/28/24 documented R6 was sent to the emergency room and received one stitch in both fingers. The recommendation was to remind R6 to call for assistance when getting up and ambulating. On 07/02/24, an X-ray report revealed that the left hand had a nondisplaced fracture at the base of the fourth digit and a questionable non-displaced fracture at the base of the third digit. The Progress Notes dated 07/10/24 at 09:56 AM documented that R6 was heard yelling and found lying on the floor. The note reported R6 had got up on her own. The physician ordered an X-ray of the right hip and pelvis. The Incident Summary dated 07/10/24 documented that R6 was unattended and had gotten up out of her chair, and R6 was given a reacher (previous intervention) and shown how to use it so she could grab items out of her reach. And that the nursing staff would take the resident to the bathroom one hour after each meal. The CT (an X-ray technique of imaging creates detailed images) of the pelvis, dated 07/13/24, reported an acute comminated (bone break into three or more pieces) fracture of the right ischium (part of the hip bone or over the hip bone area), and the base of the inferior pubic ramus. The Progress Note dated 08/28/24 at 04:44 PM documented R6 signed a contract stating the staff/facility was not responsible for any falls. R6 had been educated on using the call light when she needed assistance, using her walker, and wearing appropriate footwear, including gripper socks. R6 had voiced understanding and was agreeable to this. (R6 had moderately impaired cognition). The chair alarm had been discontinued. The Progress Note dated 11/15/24 at 05:37 AM documented R6 was found on the floor in her room. R6 stated she tried going to the bathroom. R6 right forearm was bleeding and bruised, along with points on her hand. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Incident Summary dated 11/15/24 documented steri-stips (adhesive wound closures) placed on R6's forearm. The recommendation/action documented staff instructed that R6 was taken to the bathroom within one hour after meals. R6 was provided a reacher due to wanting to be self-sufficient. On 03/05/25 at 09:25 AM, R6 was in her room, standing at the dresser/TV stand, looking through the top drawer. The walker was parked next to the dresser. The call light was fastened to the left armrest of her recliner. On 03/05/25 at 09:30 AM, Certified Nurse Aide (CNA) M stated R6 does what she wants, staff tried to catch her when she was up to be near her. CNA M reported that R6 ate most of her meals in her room, but on occasion, she would come out to see the birds in the activity room or walk up and down the halls. On 03/05/25 at 11:00 AM, Licensed Nurse (LN) G reported that R6 was very stubborn and had poor safety awareness. LN G reviewed a document risk assessment that R6 had signed a release of responsibility form for injuries related to falls. On 03/05/25 at 01:20 PM, Administrative Nurse E verified that R6 had signed a safety education and release of responsibility form when R6 had moderately impaired cognition. Administrative Nurse E reported that the charge nurses were responsible for new interventions to prevent further falls of residents with each fall. The facility's Safety and Supervision of Residents policy, dated 07/2017, documented that the facility strived to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. The individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices and monitoring the effectiveness of interventions. Resident supervision is a core component of the system's approach to safety. The facility failed to prevent R6's falls, which resulted in pelvic and finger fractures with ineffective repeated intervention. This deficient practice placed the resident at risk for continued falls and injuries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ness County Hospital Ltcu Dba Cedar Village	312 Custer Street Ness City, KS 67560

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 22 residents. The sample included 12 residents, of which five were reviewed for medication use. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 4's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication had an approved indication for use and that R13's as-needed (PRN) antianxiety (a class of medications that calm and relax people) medication had an end-of-use date. This placed the residents at risk of receiving unnecessary psychotropic (alters mood or thought) medication. Findings included: - R4's Electronic Medical Record (EMR) included diagnoses of insomnia (inability to sleep), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (HTN - elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), and personal history of urinary tract infections. The Significant Change Minimum Data Set (MDS), dated [DATE], documented R4 had moderately impaired cognition, had verbal and physical behaviors directed at others and other behavioral symptoms that occurred one to three days of a seven day look back period and rejection of care behaviors that occurred four to six days of the seven day look back period. R4 required partial/moderate assistance with toileting hygiene, upper and lower body dressing, transfers, and ambulation. The MDS further documented R4 received scheduled pain medication, an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and an opioid (medication used to treat severe pain). The antipsychotic had no gradual dose reduction (GDR) attempt or physician documentation as clinically contraindicated. R4's Care Plan, dated 12/11/24, documented R4 took a medication regime with potential and adverse side effects. The Care Plan directed staff to monitor for possible signs and symptoms of adverse drug reactions of each medication and review pharmacy recommendations. The Physician Order dated 04/18/24 directed staff to administer Aripiprazole (an antipsychotic) two milligrams (mg) mouth at bedtime for insomnia. The Physician Order dated 04/15/24 directed staff to administer Sertraline (an antidepressant) 25 mg by mouth in the morning related to depression. The Physician Order dated 09/09/24 directed staff to administer Alprazolam (and antianxiety) 0.5 mg by mouth at bedtime related to anxiety disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Ness County Hospital Ltcu Dba Cedar Village		STREET ADDRESS, CITY, STATE, ZIP CODE 312 Custer Street Ness City, KS 67560	

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 11/26/24 directed staff to administer Norco 5-235 mg (an opioid) by mouth as needed every three hours for pain for three times a day related to pain. Review of the EMR and Consultant Pharmacist monthly review from 04/2024 to 02/2025 lacked documentation regarding the unapproved indication or risk versus benefit for the continued use of Aripiprazole for insomnia. On 03/04/25 at 11:45 AM, R4 was making her way into the dining room, sitting in a wheelchair. She was alert and pleasant with the staff. On 03/05/25 at 11:55 AM, Administrative Nurse E stated that R4's use of Aripiprazole for insomnia was not an approved indication of use. The consultant pharmacist had not notified the facility or the physician of the medication's continued use. The facility's Psychotropic Medication Use policy, dated 12/02/19, documented that the physician's order for psychotropic drugs will include both a qualifying diagnosis for drugs and a list of specific target behaviors that the staff will monitor during the drug administration. All physicians' orders for antipsychotic medications would be clear and accurate and should include a diagnosis, condition, or indication for use: and the consultant pharmacist will review the appropriateness of all medication orders for medications to be administered by clinical staff. The facility failed to ensure that R4 antipsychotic medication had an approved indication for use. This placed the resident at risk of receiving unnecessary psychotropic medication. - Resident (R) 13's Electronic Medical Record (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), altered mental status, Parkinson's (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) disease, hypertension (HTN - elevated blood pressure), insomnia (inability to sleep), and heart failure. The Significant Change Minimum Data Set (MDS), dated [DATE], documented R13 had severe cognitive impairment, inattention, disorganized thinking continuously, verbal behaviors directed toward others, and wandering which occurred one to three days of the look-back period. R13 required partial/moderate assistance with functional abilities and supervision or touch assistance with mobility. The MDS further documented R13 received scheduled pain medication, an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), a diuretic (a medication to promote the formation and excretion of urine), and an antiplatelet (medication to prevent blood cells from forming clots). R13's Care Plan, dated 01/28/25, documented that R13 was at risk for adverse reactions related to polypharmacy (regular use of multiple medications). The care plan directed staff to monitor for possible signs and symptoms of adverse drug reactions, request the physician to review and evaluate medications per their schedule, review pharmacy consultant recommendations, and follow up as indicated. The Physician Order dated 09/06/24 directed staff to administer Alprazolam 0.5 mg every eight hours as needed for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). The order lacked an end or stop date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E625	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ness County Hospital Ltcu Dba Cedar Village	312 Custer Street Ness City, KS 67560

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR and Consultant Pharmacist monthly review from 03/2024 to 02/2025 lacked of documentation for the use of as needed Alprazolam. On 03/04/25 at 09:15 AM, R13 walked independently without her walker with a rolled blanket in her hand, repeating, Sleeping in the chair. The staff retrieved her walker and offered her toileting assistance in her room. On 03/05/25 at 11:05 AM, Administrative Nurse E stated that it was the responsibility of the charge nurse to obtain and place a stop day for PRN psychotropic medications. Administrative Nurse E reported that the consultant pharmacist should have recommended a stop date as well. The facility's Psychotropic Medication Use policy, dated 12/02/19, documented that the resident's need for psychotropic medication will be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose could be lowered or discontinued. Both the physician and the nursing staff would evaluate the effectiveness of PRN orders for psychotropic drugs to manage behaviors. The facility failed to obtain a required stop date for R13 's PRN Alprazolam, which placed the resident at risk of receiving unnecessary psychotropic medication.