STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175399	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Golden Age Home	724 N Main Cheney, KS 67025

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** - The Electronic Health Record (EHR) for R2 included the diagnoses of dementia (a progressive mental disorder characterized by failing memory confusion), pain, major depressive disorder (major mood disorder which causes persistent feelings of sadness),weakness, multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord hypertension), hypertension (HTN-elevated blood pressure), urinary retention (lack of ability to urinate and empty the bladder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The admission Minimum Data Set (MDS) dated [DATE] documented that R2 had a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating intact cognition. The assessment documented R2 required extensive assistance for all ADL (activities of daily living such as walking, grooming, toileting, dressing and eating) from staff and required mechanical full body lift. The Quarterly MDS dated [DATE] documented R2 had a Brief Interview for Mental Status (BIMS) assessment score of 12, indicating intact cognition. The assessment documented R2 required extensive assistance for all cares and required the use of a mechanical full body lift. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/25/24 documented that R2 was not ambulatory and depended entirely on staff for care. R2 was at risk for injuries due to inadequate safety awareness related to cognitive decline, confusion, and anxiety. Observation on 11/14/24 at 10:50 AM revealed Certified Nurse Aide (CNA) I transported R2 in a shower chair, from the shower room to her bedroom. During the transport down the hall, R2's buttock was exposed and visible to anyone in the area. During an interview on 11/13/24 at 11:52 AM, Certified Medication Aide (CMA) S stated residents were expected to be dressed in the shower room, after being showered, before being brought in the hall to go to their room. During an interview on 11/13/24 at 10:50 AM, CNA I stated it was facility policy to transfer residents who required mechanical lifts in their rooms not in the shower room. During an interview on 11/13/24 at 11:39 AM, Licensed Nurse (LN) O stated that residents were not to be transferred in the hall in the shower chair. LN O stated that staff were to take mechanical lifts into the shower room and transfer residents there. In an interview on 11/13/24 at 01:48 PM, Administrative Staff A stated she expected staff to make (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Cheney Golden Age Home	724 N Main Cheney, KS 67025

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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	sure that residents were adequately covered after having a shower before taking them into the hall to provide dignity to the residents. Administrative Staff A confirmed she expected staff not to transfer residents in the hall with the shower chair. The facility's Right to Dignity policy, dated February 2024, documented that elders will be undressed and dressed inside the bathing room rather than being transported without full clothing. The facility failed to protect R2's dignity when staff transported R2 from the shower room to her room with her buttocks exposed. This deficient practice had the potential to lead to negative psychosocial effects related to dignity. - The Electronic Health Record (EHR) for R31 included the diagnoses of dementia (a progressive mental disorder characterized by failing memory confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Significant Change Minimum Data Set (MDS) dated 05/25/24 documented R31 was unable to complete the Brief Interview for Mental Status (BIMS) assessment. The assessment documented R31 as dependent on staff for all cares. The Quarterly (MDS) dated 08/20/24 documented that R31 was unable to complete the Brief Interview for Mental Status (BIMS) assessment, The assessment documented R31 as dependent on staff for all cares. The Care Plan initiated on 08/28/24 directed staff to clearly explain all care activities prior to and as they occur during each contact. Observation on 11/12/24 at 11:48 AM revealed Certified Nurse Aide (CNA) F, assisted by CNA D, transferred R31 with a full body mechanical lift from the bed to the geri-chair. Both staff members did not identify themselves to the resident to R31 and/or, explain the care they would perform, during the interaction. R31 yelled out while staff performed cares. Once staff completed the transfer they attempted to de-escalate the resident. R31 was agitated, unable to sit still, and was yelling out. In an interview on 11/13/24 at 04:48 AM, Administrative Nurse A stated she expected staff to communicate with residents even if the resident could not effectively communicate with staff during cares being performed. The facility's Right to Dignity policy, dated 02/2024, documented that staff will refrain from failing to focus on the elder as an individual when talking with the elder or failing to address the elder as an individual during care and services. The facility failed to protect R31's dignity when staff provided care without explaining the procedure. This deficient practice had the potential to lead to negative psychosocial effects related to dignity. The facility reported a census of 36 residents with 12 residents sampled. Based on interview, observation, and record review, the facility failed to protect the privacy and dignity of three residents; Resident (R) 35 when a medication was administered via percutaneous endoscope gastrostomy tube (PEG - a tube inserted through the wall of the abdomen directly into the stomach) with her left breast exposed and the door to the room stood open, failed to explain procedures to R31 when providing (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cares, and further failed to provide privacy to when staff transported R2 from the shower room to her room with her buttocks exposed. These practices had the potential to lead to negative psychosocial effects related to dignity. Findings included: - The Electronic Health Record (EHR) for R35 included the diagnoses of: nontraumatic intracerebral hemorrhage (bleeding in the brain not caused by trauma), need for assistance with personal cares, generalized muscle weakness and dysphagia (difficulty or inability to swallow). The admission Minimum Data Set (MDS) dated 10/22/24 documented a Brief Interview for Mental Status score of nine which indicated moderately impaired cognition. The assessment documented R35 as dependent on staff for all cares and had a feeding tube (PEG tube). The Nutritional Status Care Area Assessment (CAA) dated 10/22/24 documented R35 required tube feedings and was dependent on staff. Observation on 11/14/24 at 08:11 AM of Administrative Nurse B administering medication via PEG and R35's left breast partially exposed during the procedure. Interview on 11/14/24 at 08:25 AM Administrative Nurse B stated that her expectation was for the door to resident's rooms to be closed during cares or procedures to provide dignity to the residents. Additionally, Administrative Nurse B confirmed that the door to R35's room was open during the administration of medications via PEG tube and R35's left breast was partially exposed. During an interview on 11/14/24 at 08:30 AM R35 stated she was bothered that the door to her room was open during the time when the PEG tube was exposed and her left breast was partially exposed. The facility's Right to Dignity policy, dated 02/2024 documented the facility would promote care for elders of the facility in a manner and environment that maintains and enhances the elder's dignity and respect. The facility failed to protect the dignity of R35 when the door to R35's room was left open when a medication was administered via PEG tube with the PEG tube exposed and R35's left breast partially exposed. This deficient practice had the potential to lead to negative psychosocial effects related to dignity.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 36 residents. The sample included 12 residents with three reviewed for hospitalization. Based on observation, interview, and record review the facility failed to provide written notice for facility-initiated transfers for Residents (R) 11, R2, or R6 or their representative when they were transferred to the hospital. Findings included: - Review of the Electronic Health Record (EHR) census log for R11 revealed a discharge from the facility to a hospital on [DATE] and noted the resident readmitted to the facility on [DATE]. The census log also documented a discharge from the facility to a hospital on [DATE] and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative related to this discharge/transfer. Review of the EHR census log for R6 revealed a discharge from the facility to a hospital on [DATE] and readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative related to these discharges/transfers. Review of the EHR census log for R2 revealed a discharge from the facility to a hospital on [DATE] and noted the resident was readmitted to the facility on [DATE]. The EHR lacked documentation related to written notification of the resident or resident's representative related to this discharge/transfer. During an interview on 11/18/24 at 09:35 AM with Administrative Nurse K revealed the charge nurse on duty at the time of a hospitalization was responsible for the paperwork which includes a bed hold. The nurse would call the resident's representative and obtain verbal consent for the bed hold then submit the paperwork to the Business Office Manager who would call the resident's representative either later that day or on the next business day to confirm the authorization for a bed hold. Administrative Nurse K stated she was unsure if a written notice was provided to the resident or resident's representative. During an interview on 11/18/24 at 10:20 AM with Administrative Staff T and Administrative Staff A confirmed the nurse on duty at the time of a hospitalization would fill out a bed hold form, call the resident's representative, and obtain verbal consent for the bed hold then send the paperwork to the business office for verification later that day or on the next business day. Administrative Staff A confirmed bed holds were not submitted to the resident or resident's representatives in writing. Administrative Staff A stated she was unaware of the regulatory requirement that a written notice be given to the resident or resident's representative upon transfer/discharge. The facility failed to provide a policy related to discharge notifications. The facility failed to provide written notification of facility-initiated discharges/transfers to the residents, the resident's representative.

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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** The facility identified a census of 36 residents, which included 12 residents sampled. Based on interviews, observations, and record review, the facility failed to review and revise care plans with appropriate interventions for two of the sampled residents; Resident (R) 6 related to development and implementation of appropriate interventions to prevent additional falls and R11 related to storage of continuous positive airway pressure (CPAP - a device that provides continuous air pressure to keep the upper airway open during sleep) equipment when not in use. These deficient practices resulted in uncommunicated care needs. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 11 included the diagnosis of obstructive sleep apnea (OSA- a sleep related breathing disorder that cause people to stop and start breathing while asleep). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The assessment documented R11 required substantial/maximal assistance for dressing, partial/moderate assistance for bathing and supervision/setup for all other cares and used a CPAP device. The 09/26/24 Care Plan documented on 09/25/23 that R11 utilized a CPAP machine at night and while napping, initiated on 09/25/23 and revised on 01/22/24. The Physician's Orders documented CPAP at home settings at HS (hour of sleep or bedtime) and when napping, every shift, initiated on 10/05/23. During an observation on 11/12/24 at 01:05 PM, 11/14/24 at 07:50 AM, 11/18/24 at 08:30 AM and 11/18/24 at 12:28 PM of R11's room revealed CPAP equipment sat intact on R11's bedside cabinet and lacked sanitary cover or bag. During an interview on 11/18/24 at 09:53 AM, Certified Nurse Aide (CNA) I stated cannulas and other oxygen delivery equipment including CPAP equipment should be stowed in a sanitary bag when not in use. During an interview on 11/18/24 at 10:04 AM, CNA J stated that CNA staff could assist residents in donning or doffing their cannulas and CPAP equipment and that all respiratory equipment should be stowed in the sanitary bags in their room when not in use. During an interview on 11/18/24 at 11:34 AM, Certified Medication Aide (CMA) C stated that CMA staff were responsible for changing out the CPAP and oxygen equipment and that oxygen equipment should be stowed in the sanitary bag when not in use. Further, stated that she was unsure of how CPAP mask/tubing should be stowed when not in use. During an interview on 11/28/24 at 12:28 PM, Administrative Nurse B confirmed that R11's CPAP mask was not stowed in a sanitary bag. Administrative Nurse B then retrieved a sanitary bag from the bottom drawer of R11's bedside cabinet that contained other un-bagged CPAP masks and placed R11's CPAP (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mask from the top of the bedside cabinet without cleaning it into the sanitary bag. Administrative Nurse B then educated R11 to place the CPAP mask in the sanitary bag when not in use. Administrative Nurse B stated R11's care plan should include an intervention for staff to place the mask inside the bag if the mask was discovered not stowed appropriately and confirmed the lack of an intervention of R11's care plan for staff to stow R11's CPAP mask in the sanitary bag. The facility's Person Centered, Comprehensive Care Plans policy, dated 12/2023 documented the facility would provide an individualized and person-centered plan of care for all residents that was appropriate for the resident's needs. Additionally documented the facility would review and revise the care plan quarterly, or more frequently, to include interventions which direct and instruct staff to meet the goals of the resident. The facility failed to review and revise R11's comprehensive person-centered care plan to include interventions to place R11's CPAP mask in a sanitary bag when not in use. This deficient practice placed R11 at risk of uncommunicated care needs. - Review of the Electronic Health Record (EHR) for Resident (R) 6 included the following diagnoses: lack of coordination, morbid (severe) obesity (excessive body fat), hemiplegia (muscular weakness of one half of the body), hemiparesis (paralysis of one side of the body), cerebrovascular disease (conditions that affect the blood vessels in the brain and spinal cord can), hypertension (elevated blood pressure), and lymphedema (swelling caused by accumulation of lymph). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R6 had a Brief Interview for Mental Status (BIMS) assessment score of 13, indicating intact cognition. The assessment documented R6 required substantial or maximum assistance from staff for transfers. R6 was dependent on staff to perform other cares. The MDS indicated R6 had no falls during the documented review period. The Quarterly MDS dated [DATE], documented a BIMS of 13, which indicated intact cognition. The MDS indicated R6 had no falls during the documented review period. The Falls Care Area Assessment (CAA) dated 07/07/24, documented R6 had a fall risk, but lacked documentation noting R6 had any falls. The resident's Care Plan lacked an intervention for the fall dated 06/25/24. The Progress Note dated 06/25/24 at 07:15 PM indicated that the nurse was requested to go to the shower room to perform a skin assessment. The nurse needed more treatment supplies and exited the shower room. Upon the nurse's reentry into the shower room, the staff successfully assisted R6 in standing for the second time. The resident could not maintain her standing position during the wound treatment and attempted to sit down without the wheelchair positioned behind her. Staff assisted R6 to the floor while waiting for more staff to assist with the transfer. (The facility failed to document this as a fall or initiate their fall policy related to this documentation.) Review of the facility Fall Investigation for R6 lacked documentation related to a fall on 06/25/24. The Progress Note dated 06/26/24 at 09:00 AM, revealed that R6 complained of right foot pain and difficulty bearing weight on it. The staff notified the resident's provider, who ordered an X-ray. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The review of Physician Extender Summary dated 06/27/24 at 04:20 PM, revealed that during a transfer to the shower two days prior, it was believed that R6's right lower leg was caught in the chair. An X-ray was performed and revealed a non-displaced distal tibia fracture of the lower end of the right tibia. Observation on 11/14/24 at 09:00 AM, revealed R6 sitting in her wheelchair playing on her tablet alone in her room, with her right arm in a sling. The resident lacked a boot on her right foot. Observation on 11/14/24 at 08:19 AM, revealed Certified Medication Aide (CMA) S assisted R6 with a pivot transfer to the bathroom with one assist and resident was able to tolerate transfer comfortably without complaints of pain and able to bear own weight. On 11/18/24 at 08:30 AM, Certified Nurse Aide (CNA) P stated a fall would be defined as any time a resident's body contacts the floor. CNA P stated she did not think R6's care plan had undergone any change for the last seven months of her employment. CNA P knew of care plan changes either by the Point Click Care (POC) banner when logging in to chart or verbally when starting the shift during report from the previous shift. On 11/18/24 at 09:23 AM, Licensed Nurse (LN) M stated a fall would be defined as anytime a resident unintentionally went from a higher surface to a lower surface. LN M stated R6 had one fall that she knew, in October, which resulted in no injury. LN M stated immediately at that time she put the intervention in place for R6 to wait for help before transferring herself. On 11/18/24 at 10:34 AM, Administrative Staff A stated when any resident unintentionally went from a higher surface to a lower surface would be considered a fall. Administrative Staff A stated even when a resident had to be assisted to the floor by staff the facility classified that instance as an assisted fall. Administrative Staff A stated that the facility required any assisted fall to be recorded as a fall. Review of facility's Fall Follow-Up Protocol dated February 2024 documented: A fall refers to an incident where a resident, without intention, fails to maintain their balance and descends to a lower level. This definition encompasses situations where the resident would have fallen if not for the timely intervention of care partners. This definition stands regardless of whether the resident sustains an injury or not. The facility failed to revise the care plan for R6 after a fall to prevent further falls. This deficient practice had the potential to negatively affect R6's physical well-being related to the ongoing risk of falls.

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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** The facility census totaled 36 residents, with 12 residents included in the sample. Based on observation, interview, and record review, the facility failed to identify a fall, investigate causal factors, and implement fall prevention interventions for Resident (R)6 to prevent further falls. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R)6 included the following diagnoses: lack of coordination, morbid (severe) obesity (excessive body fat), hemiplegia (muscular weakness of one half of the body), hemiparesis (paralysis of one side of the body), cerebrovascular disease (conditions that affect the blood vessels in the brain and spinal cord can), hypertension (elevated blood pressure), and lymphedema (swelling caused by accumulation of lymph). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R6 had a Brief Interview for Mental Status (BIMS) assessment score of 13, indicating intact cognition. The assessment documented R6 required substantial or maximum assistance from staff for transfers, and noted R6 was dependent on staff to perform other cares. The MDS indicated R6 had no falls during the documented review period. The Quarterly MDS dated [DATE], documented a BIMS of 13, which indicated intact cognition. The MDS indicated R6 had no falls during the documented review period. The Falls Care Area Assessment (CAA) dated 07/07/24, documented R6 had a fall risk, but lacked documentation noting R6 had any falls. The resident's Care Plan lacked an intervention for the fall dated 06/25/24. The Progress Note dated 06/25/24 at 07:15 PM indicated that the nurse was requested to go to the shower room to perform a skin assessment. The nurse needed more treatment supplies and exited the shower room. Upon the nurse's reentry into the shower room, the staff successfully assisted R6 in standing for the second time. The resident could not maintain her standing position during the wound treatment and attempted to sit down without the wheelchair positioned behind her. Staff assisted R6 to the floor while waiting for more staff to assist with the transfer. (The facility failed to document this as a fall or initiate their fall policy related to this documentation.) Review of the facility Fall Investigation for R6 lacked documentation related to a fall on 06/25/24. The Progress Note dated 06/26/24 at 09:00 AM revealed that R6 complained of right foot pain and difficulty bearing weight on it. The staff notified the resident's provider, who ordered an X-ray. The review of Physician Extender Summary dated 06/27/24 at 04:20 PM revealed that during a transfer to the shower two days prior, it was believed that R6's right lower leg was caught in the chair. An X-ray was performed and revealed a non-displaced distal tibia fracture of the lower end of the right tibia. (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 11/14/24 at 09:00 AM, revealed R6 sitting in her wheelchair playing on her tablet alone in her room, with her right arm in a sling. The resident lacked a boot on her right foot. Observation on 11/14/24 at 08:19 AM, revealed Certified Medication Aide (CMA) CMA S assisted R6 with a pivot transfer to the bathroom with one assist and resident was able to tolerate transfer comfortably without complaints of pain and able to bear own weight. On 11/18/24 at 08:30 AM, Certified Nurse Aide (CNA) P stated a fall would be defined as any time a resident's body contacts the floor. CNA P stated she did not think R6's care plan had undergone any change for the last seven months of her employment. CNA P knew of care plan changes either by the Point Click Care (POC) banner when logging in to chart or verbally when starting the shift during report from the previous shift. On 11/18/24 at 09:23 AM, Licensed Nurse (LN) M stated a fall would be defined as anytime a resident unintentionally went from a higher surface to a lower surface. LN M stated R6 had one fall that she knew, in October, which resulted in no injury. LN M stated immediately at that time she put the intervention in place for R6 to wait for help before transferring herself. On 11/18/24 at 10:34 AM, Administrative Staff A stated when any resident unintentionally went from a higher surface to a lower surface would be considered a fall. Administrative Staff A stated even when a resident had to be assisted to the floor by staff the facility classified that instance as an assisted fall. Administrative Staff A stated that the facility required any assisted fall to be recorded as a fall. Review of facility's Fall Follow-Up Protocol dated February 2024 documented: A fall refers to an incident where a resident, without intention, fails to maintain their balance and descends to a lower level. This definition encompasses situations where the resident would have fallen if not for the timely intervention of care partners. This definition stands regardless of whether the resident sustains an injury or not. The facility failed to identify a fall, investigate causal factors, and implement fall prevention interventions for R6 to prevent further falls. This deficient practice had the potential to negatively affect R6's physical well-being related to the ongoing risk of falls.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility reported a census of 36 residents. Based on interview and record review, the facility failed to conduct annual performance reviews for five of the five sampled Certified Nurse Aides, employed with the facility over a year. Findings included: - During review of employment records for the five Certified Medication Aide (CMA)/Certified Nurse Aides (CNA) staff, employed by the facility for over a year, revealed the facility failed to complete annual performance review for the following direct care staff: 1. CNA/CMA C, hired 01/22/04 2. CNA D, hired 08/24/23 3. CNA E, hired 06/07/23 4. CNA F, hired 09/18/06 5. CNA G, hired 1/26/23 On 11/18/24 at 03:03 PM, Administrative Staff A confirmed the above findings and said she could not locate the most recent performance evaluations. Administrative Staff A stated that all staff should have a performance evaluation annually. Administrative Staff A confirmed that direct care staff worked with all residents throughout the facility. The facility did not provide a policy to address the completion of annual performance evaluations. The facility failed to conduct annual performance reviews for five of the five sampled Certified Nurse Aides, employed with the facility for over a year, who provided care for all residents of 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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility reported a census of 36 residents. Based on interview and record review, the facility failed to electronically submit complete and accurate staffing information to the Federal regulatory agency through Payroll-Based Journal (PBJ) when the facility failed to accurately submit hourly staffing data for all nursing personnel. Findings included: - Review of the PBJ Staffing Data Report for Fiscal Year (FY) for Quarter 3- 2024 (April 1 - June 30), the data indicated the facility failed to have Licensed Nursing Coverage 24 hours/Day on the following dates: 05/04/24 Saturday (SA), 05/12/24 Sunday (SU), 05/18/24 (SU), 06/02/24 (SA), 06/15/24 (SA), 06/16/24 (SU), 06/23/24 (SU) and 06/29/24 (SA). Review of the Nursing Schedule and Payroll Data Sheets for the above dates revealed the facility had adequate 24-hour nursing coverage. On 11/18/24 at 08:00 AM, Administrative Staff A reported payroll data and scheduling data reflected the facility had 24 hour nursing coverage. Administrative Staff A stated nursing staff were directed to not clock out for lunch if they did not leave the building and stated they could only leave the building if the responsibilities were covered by another licensed nurse. Administrative Staff A reported the facility had been having problems getting their payroll contractor to accurately account for time where agency staff covered the shift. On 11/18/24 at 01:00 PM, Administrative Nurse B provided documentation to support adequate 24-hour nursing coverage for the listed dates. The facility's Payroll Based Journal Policy policy, dated 03/2024 documented the facility aimes to ensure complaince with Federal regulations to promote transparency and accountability for the workforce management. Additionally documented that the facility would report the hours worked from agency employees through the PBJ system. The facility failed to submit complete and accurate staffing information to the Federal regulatory agency through PBJ when the facility failed to accurately submit hourly staffing data for all nursing personnel.

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	175399	A. Building B. Wing	11/18/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - Review of the Electronic Health Record (EHR) for Resident (R)2 included a diagnosis of urinary retention (lack of ability to urinate and empty the bladder) and multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord hypertension). The Comprehensive Minimum Data Set (MDS) dated [DATE] documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R2 required extensive assistance for all Activities of Daily Living (ADL) such as walking, grooming, toileting, dressing, and eating. The MDS did not identify R2 had an indwelling urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). The Quarterly MDS dated [DATE] documented R2 had a BIMS score of 12, which indicated intact cognition. The assessment documented R2 had an indwelling urinary catheter. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 05/25/24 documented R2 was incontinent of bladder and bowel and staff would monitor and make interventions to prevent infections. The 08/22/24 Care Plan documented R2 required enhanced barrier precautions (EBP, apply to residents with wounds or indwelling medical devices, regardless of whether they are known to be infected) and staff should utilize EBP due to indwelling device regardless of Multi-Drug Resistant Organism (MDRO - a common bacteria that have developed resistance to multiple types of antibiotics) and for Healthcare Acquired Infections (HAI - infections acquired in a healthcare setting) colonization status including but not limited to the use of a urinary catheter and was last revised on 04/01/24. The 08/22/24 Care Plan documented EBP would be utilized per facility policy and procedures if criteria had been met, revised on 04/01/24. The 08/22/24 Care Plan documented if criteria were met, resident would be identified by signage placed on the outside of the bedroom door which indicated precautions, revised on 04/01/24. The Physician's Orders included a Foley (a brand of catheter) catheter change as needed (PRN) related to decreased urinary flow due to possible obstruction, initiated on 08/06/24. The Physician's Orders documented a Foley Catheter change monthly on the 21st of every month initiated on 08/21/24. During an observation on 11/12/24 at 11:41 AM, the door to R2's room lacked signage that indicated EBP was required. During and observation on 11/12/24 at 01:23 PM, the door to R2's room displayed a sign that indicated EBP was required. During an observation on 11/13/24 at 01:34 PM, Certified Nurse Aide (CNA) F and CNA J moved a mechanical lift from R2's room into different resident's room, without cleaning the mechanical lift. (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 11/14/24 at 08:13 AM, CNA I preformed catheter care on R2 and used only gloves. CNA, I did not use EBP until 08:39 AM when another staff member entered the room and reminded CNA I that R2's catheter care required the use of EBP. During an interview on 11/13/24 at 02:16 PM, CNA J stated she knew that mechanical lifts used in a resident's room which required EBP, required cleaning and sanitizing with disinfectant wipes before it was used in another resident's room. During an interview on 11/14/24 at 08:24 AM, CNA I stated the sign on R2's door blended into the door which made it hard to see and did not stand out. CNA I stated she was not aware that R2 was on EBP because the sign was not highly visible, and a second person in the room with her helped her perform the correct level of PPE (personal protective equipment, such as gloves/gown/mask). CNA I stated if there would have been a red trash cans that would have prompted her to stop. In an interview on 11/13/24 at 02:29 PM Licensed Nurse (LN) O stated staff should wipe down mechanical lifts with antimicrobial wipes after using the lift in a resident's room that required EBP. During an interview on 11/28/24 at 12:28 PM, Administrative Staff A confirmed the staff were expected to disinfect the mechanical lift after use in residents' room that required EBP. The facility did not provide a policy to address EBP expectations to prevent infection and/or cross contamination. The facility failed to ensure staff donned appropriate PPE while providing catheter care for R2, who was on EBP precautions. This deficient practice had the potential to lead to cross contamination that would negatively impact R2's physical and psychosocial well-being. - Review of the Electronic Health Record (EHR) for Resident (R) 6 included a diagnosis of obstructive sleep apnea (OSA - a sleep related breathing disorder that cause people to stop and start breathing while asleep). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R6 had a Brief Interview for Mental Status (BIMS) assessment score of 13, indicating intact cognition. The assessment documented R6 required substantial or maximum assistance from staff for transfers. R6 was dependent on staff to perform other cares. The assessment documented R6 required substantial/maximal assistance for dressing, partial/moderate assistance for bathing, and supervision/setup for all other cares and used a CPAP continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep) device. The Care Plan initiated on 10/14/24 documented R6 utilized a CPAP machine at night, revised on 01/03/23. The Physician's Orders documented the resident required a CPAP at HS (hour of sleep or bedtime) with oxygen, check oxygen saturations every night, initiated on 02/05/22. During an observation on 11/12/24 at 11:48 AM, 11/13/24 at 12:42 PM, 11/14/24 at 08:19 AM, and 11/14/24 at 09:30 AM of R6's room revealed CPAP equipment sat intact on R6's bedside cabinet and lacked a sanitary cover or bag. (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 11/18/24 at 09:53 AM, Certified Nurse Aide (CNA) I stated oxygen cannulas and other oxygen delivery equipment including CPAP equipment should be stowed in a sanitary bag when not in use. During an interview on 11/18/24 at 10:04 AM, CNA J stated CNA staff could assist residents in donning or doffing their oxygen cannulas and CPAP equipment and that all respiratory equipment should be stowed in the sanitary bags in their room when not in use. During an interview on 11/18/24 at 11:34 AM, Certified Medication Aide (CMA) C stated CMA staff were responsible for changing out the CPAP and oxygen equipment and that oxygen equipment should be stowed in the sanitary bag when not in use. CMA C stated that she was unsure of how CPAP mask/tubing should be stowed when not in use. During an interview on 11/28/24 at 12:28 PM, Administrative Nurse B confirmed R6's CPAP mask was not stowed in a sanitary bag. Administrative Nurse B then educated R6 to place the CPAP mask in the sanitary bag when not in use. Administrative Nurse B confirmed R6's being stowed on top of the bedside cabinet was an infection control concern. The facility did not provide a policy to address available storage of oxygen, nasal cannulas, and tubing, when not in use to prevent infection and/or cross contamination. The facility failed to ensure R6's CPAP equipment was stowed appropriately to prevent the spread of illnesses. - Review of the Electronic Health Record (EHR) for Resident (R) 11 included a diagnosis of obstructive sleep apnea (OSA - a sleep related breathing disorder that cause people to stop and start breathing while asleep). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The assessment documented R11 required substantial/maximum assistance for dressing, partial/moderate assistance for bathing, and supervision/setup for all other cares and used a CPAP device. The 09/26/24 Care Plan documented on R11 utilized a CPAP machine at night and while napping, initiated on 09/25/23, and revised on 01/22/24. The Physician's Orders documented CPAP at home settings at HS (hour of sleep or bedtime) and when napping, every shift, initiated on 10/05/23. During an observation on 11/12/24 at 01:05 PM, 11/14/24 at 07:50 AM, 11/18/24 at 08:30 AM, and 11/18/24 at 12:28 PM of R11's room revealed the CPAP equipment sat intact on R11's bedside cabinet and lacked a sanitary cover or bag. During an interview on 11/18/24 at 09:53 AM, Certified Nurse Aide (CNA) I stated cannulas and other oxygen delivery equipment including CPAP equipment should be stowed in a sanitary bag when not in use. During an interview on 11/18/24 at 10:04 AM, CNA J stated the CNA staff could assist residents in donning or doffing their cannulas and CPAP equipment and that all respiratory equipment should be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stowed in the sanitary bags in their room when not in use. During an interview on 11/18/24 at 11:34 AM, Certified Medication Aide (CMA) C stated that CMA staff were responsible for changing out the CPAP and oxygen equipment and that oxygen equipment should be stowed in the sanitary bag when not in use. Further, stated that she was unsure of how CPAP mask/tubing should be stowed when not in use. During an interview on 11/28/24 at 12:28 PM, Administrative Nurse B confirmed that R11's CPAP mask was not stowed in a sanitary bag. Administrative Nurse B then retrieved a sanitary bag from the bottom drawer of R11's bedside cabinet that contained other un-bagged CPAP masks and placed R11's CPAP mask from the top of the bedside cabinet without cleaning it into the sanitary bag. Administrative Nurse B then educated R11 to place the CPAP mask in the sanitary bag when not in use. Administrative Nurse B confirmed R11's being stowed on top of the bedside cabinet was an infection control concern. The facility did not provide an infection control policy directly related to respiratory equipment. The facility failed to ensure R11's CPAP equipment was stowed appropriately to prevent the spread of illnesses. This deficient practice had the potential to lead to respiratory illnesses that would negatively impact R11's physical and psychosocial well-being. The facility reported a census of 36 residents which included 12 sampled. Based on observation, interview, and record review, the facility failed to ensure a sanitary environment to prevent the potential spread of infectious organisms. The facility did not ensure sanitary storage of respiratory equipment to include nasal cannulas and oxygen tubing for Resident (R)26, R6, and R11. The facility did not ensure the appropriate use of personal protective equipment (PPE) related to enhanced barrier precautions for R2, who had a catheter. The staff wore PPE throughout one of three hallways of the facility. The facility failed to clean/sanitize the full body lift between use for multiple residents. Finding included: - Review of Resident (R)26's Physician Orders, dated 10/31/24, revealed diagnoses which included chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure, (CHF-a condition with low heart output and the body becomes congested with fluid), pain, altered mental status, and dementia (progressive mental disorder characterized by failing memory, confusion). The admission Minimum Data Set (MDS) dated [DATE], documented the Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. The MDS noted R26 received oxygen. The Quarterly MDS dated [DATE], documented the Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. The MDS noted the resident received oxygen. The Care Plan dated 10/25/24, lacked directions to staff for storage of oxygen cannulas when not in use. The Physician's Orders dated 10/31/24, included Oxygen two liters (L), per nasal cannula, to keep oxygen saturations above 90 percent (%), every shift, ordered 07/11/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/13/24 at 08:30 AM, R26 sat in her chair without her oxygen in use. The oxygen nasal cannula laid directly on top of the oxygen concentrator at the handle. The connective tubing laid directly on the floor beside the resident's chair. The oxygen concentrator lacked a storage bag to place the oxygen tubing when not in use to prevent cross contamination and infection. The resident reported she only used the oxygen at night and she had never had a storage bag to place her oxygen in, when not in use. During an observation on 11/13/24 at 04:20 PM the resident's oxygen nasal cannula laid under the handle of the concentrator in a rolled position. There was no storage bag available to store the nasal cannula when not in use to prevent cross contamination or infection. On 11/14/24 at 08:32 AM, Certified Nurse Aide (CNA) F stated the resident did use her oxygen. CNA F thought there should be a bag or something for the resident to store her oxygen tubing in when not in use to prevent the spread of infection. CNA F stated she did not know who was responsible for providing the bag but thought the Certified Medication Aides (CMA) took care of the oxygen cannulas, tubing, and supplies, such as storage bags. On 11/14/24 at 01:57 PM, Licensed Nurse (LN) O, report the resident's oxygen supplies were changed once a week on night shift. LN O stated R26 took her own oxygen off and placed it on the concentrator. She stated the cannula should be stored in some type of container when not in use to prevent cross contamination or infection. LN O could not recall seeing a storage bag available in the resident's room to store the oxygen cannula and tubing, when not in use. On 11/18/24 at 12:19 PM, Administrative Nurse B reported the respiratory equipment should have a bag available to store the oxygen tubing and cannula when not in use to prevent cross contamination and infection. Administrative Nurse B stated the facility provided bags for storage and thought they may be in the resident's closets. On 11/18/24 at 12:28 PM, Administrative Nurse B confirmed masks, cannulas, and tubing not stored in a bag when not in use was an infection control concern. The facility did not provide a policy to address available storage of oxygen, nasal cannulas, and tubing when not in use to prevent infection and/or cross contamination. The facility failed to provide a sanitary and safe environment to prevent cross contamination and infection related to available storage of nasal cannulas and oxygen tubing when not in use.