STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175463	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tanglewood Nursing & Rehabilitation	5015 SW 28th Street Topeka, KS 66614

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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility identified a census of 46 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to maintain safe and comfortable temperature levels for residents in the facility. On 11/22/24, Administrative Staff B received reports that one of the halls was cold. Administrative Staff B arranged for a maintenance company to assess the problem and a part was required for repair. The part was set to come in on 11/26/24. The facility supplied extra blankets and residents wore their coats inside but reported being extremely cold and experiencing physical discomfort over the weekend and on 11/25/24. On 11/26/24 around 10:00 AM, surveyor observation revealed temperatures on one hall as low as 46.9 degrees Fahrenheit (F.) Multiple temperatures were assessed between 10:10 AM and 10:15 AM with temperatures measuring in the mid to high 40s and low 50's. Multiple residents reported feeling very cold and were unable to go about daily activities due to the cold. No additional heat was provided from 11/22/24 through 12:00 PM on 11/26/24. This failure placed all affected residents in immediate jeopardy. Findings included: - During the initial tour of the facility on 11/26/24 the survey team noted the hall referred to as Long Hall was colder than the rest of the facility. The exit door had a rolled blanket at the base of the door. Both staff and residents reported cold temperatures in the hall. On 11/26/24 at 08:15 AM, Resident (R) 2 sat in his recliner with two blankets pulled up around his neck, and cool air blowing from the ceiling vent. R2 stated he was cold and wished the facility would get the heating fixed. R2 reported his room had been cold for two weeks. On 11/26/24 at 08:33 AM, R1 greeted the surveyor in the hallway as he came from the dining room. R1 reported his room had been cold for two weeks, and stated, You ought to try living with the temperature so cold, and indicated discomfort with the room temperature. R1 stated he reported the room temperature to the maintenance personnel, but the maintenance personnel's employment at the facility ended on 11/15/24. On 11/26/24 at 08:35 AM, R3 rested in bed with blankets pulled up to his neck and stated he was cold. On 11/26/24 at 09:15 AM, R4 sat on her bed watching TV while wearing a jacket. R4 reported her room had been cold for two weeks and she felt ill due to the room being so cold. R4 reported she told numerous staff about the room temperature. R2 also stated the staff used the outside door next to her room which let cold air into the building. (continued on next page)

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

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/26/24 at 09:45 AM, R5 lay in bed with a winter coat and comforter on. When asked if R5 was cold, she nodded yes. On 11/26/24 at 09:50 AM, R6 reported her room temperature was cold. On 11/26/24 at 09:55 AM, R7 stated she reported her room was cold and the facility did not have enough blankets. R7 stated she remained in bed because it was warmer than sitting in her wheelchair. R7 stated the facility staff reported the heating would be fixed that day. On 11/26/24 at 10:10 AM, the following room temperatures were obtained: R1 and R2's shared room was 46.9 degrees F. R4 and R20's shared room was 48.6 degrees F. R8 and R14's shared room was 49.2 degrees F. R9 and R10's shared room was 54.9 degrees F. R11 and R12's shared room was 55.2 degrees F. On 11/26/24 at 10:15 AM the following room temperatures were obtained: R13 and R21's shared room was 52.7 degrees F. R17 and R22's shared room was 60 degrees F. On 11/26/24 at 12:00 PM, the following temperatures were obtained: R5 and R15's shared room was 60 degrees F. R6 and R7's shared room was 59 degrees F. R23 and R24's shared room was 60 degrees F. The Weather Underground documented the following temperatures from 11/22/24 through 11/26/24 during the timeframes no additional heating was provided by the facility: On 11/22/24, the low was 25 degrees F at 06:00 AM and the high was 49 degrees F at 04:00 PM. On 11/23/24, the low was 28 degrees F at 03:00 PM and the high was 61 degrees F at 03:00 PM. On 11/24/24, the high was 66 degrees F at 04:00 PM and the low was 43 degrees F at 11:50 PM. On 11/25/24, the high was 43 degrees F at 03:30 PM and the low was 22 degrees F at 11:50 PM. On 11/26/24, the temperature was 23 degrees F at 08:00 AM and 36 degrees F at 10:00 AM. On 11/26/24 at 09:20 AM, Certified Medication Aide (CMA) R stated the residents of Long Hall (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	reported being cold. CMA R stated someone came and looked at the heating on 11/22/24 and she thought the heat was scheduled to be repaired today. CMA R reported staff provided the residents with double blankets and left their room doors open to the hallway for warmth. CMA R said staff encouraged the residents to sit near the center of the facility for the warmer temperatures. On 11/26/24 at 10:05 AM, Licensed Nurse (LN) G stated the facility had enough blankets to give extra to the residents who wanted one. LN G stated she heard about the cold temperatures inside the facility at the end of the previous week. On 11/26/24 at 10:20 AM, Administrative Staff B stated the staff reported that Long Hall was cooler than the other halls and she contacted a company to come out and check the problem on Friday, 11/22/24. Administrative Staff B said the contracted company ordered a part and the part would arrive, and the heating problem would be repaired on 11/26/24. Administrative Staff B measured some room temperatures with the surveyor. Administrative Staff B verified the room temperatures in R8 and R14's shared room as 53.7 degrees F, R4 and R20's shared room was 48.6 degrees F, R1 and R2's shared room was 46.9 degrees F, and R13 and R21's shared room was 53.7 degrees F. Administrative Staff B stated the room temperatures were alarming and that she would contact the repair company to have them come and fix the problem as soon as possible. She added that she thought the company would be at the facility by noon that day. The facility's Quality of Life-Homelike Environment policy, dated 10/2009, directed the facility to provide residents with a safe, clean, comfortable, and homelike environment. The policy directed the facility staff and management to maximize, to the extent possible, the characteristics of the facility that reflected a personalized, homelike setting which included comfortable temperatures. On 11/26/24 at 01:03 PM, Administrative Staff B received a copy of the Immediate Jeopardy [IJ] template and was informed of the facility's failure to maintain the appropriate required temperatures to ensure a safe and comfortable environment placed the affected residents in IJ. On 11/26/24 at 04:16 PM, the facility submitted an acceptable plan for corrective actions to remove the immediacy. The plan documented the following actions: The facility purchased safe-touch space heaters to provide additional heat. Staff were assigned to monitor the space heaters continuously. The facility audited the number of available blankets and purchased additional blankets to ensure availability to any resident who wanted or needed one. Ambient temperatures were assessed hourly until the temperature reached 71 degrees F. Staff interviewed residents every hour to assess resident comfort and provide additional blankets until residents expressed comfort. The part for the heater was ordered on 11/22/24 and expected to arrive at the facility on 11/27/24. The corrective actions and subsequent temperatures were verified onsite. After the removal of the immediacy, the deficient practice remained at the scope and severity of H to represent the actual physical discomfort as well as the psychosocial impact for the residents unable to self-identify or express their feelings.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 49 residents. The sample included 13 residents with three sampled residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R) 7's transfer or discharge was documented in the resident ' s medical record and appropriate information was communicated to the receiving healthcare institution or provider. This placed R7 at risk for delayed treatment and impaired continuity of care. Findings included: - The electronic medical record (EMR) for R7 documented diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), respiratory failure (a condition where your blood does not have enough oxygen), dysphagia (swallowing difficulty), aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R7's Discharge MDS dated [DATE] documented an unplanned discharge to an acute hospital with a return anticipated. R7's Entry MDS dated [DATE] documented a reentry after a short-term acute hospital stay. R7's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R7 had a swallowing disorder and required a feeding tube for nutrition. R7 was at risk of 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). R7's Nutritional Care Area Assessment (CAA) dated 10/01/24 documented he had a potential nutrition risk related to a medical history of cerebral infarction, dysphagia, and COPD and received nothing by mouth (NPO); he was dependent on enteral nutrition support to meet all estimated nutrient needs. R7's Care Plan documented a resolved care area dated 02/06/24 directing staff to provide written instruction as required to ensure care continuity post-discharge. The care plan last revised on 10/14/24 lacked staff direction regarding discharge. A review of R7's Progress Notes from 05/21/24 revealed he was sent out to the hospital after a coughing episode after attempting to swallow food. R7's Progress Reports reviewed from 09/13/24 to 09/19/24 lacked any documentation related to R7 ' s change in status and transfer to an acute hospital. R7's clinical record tab lacked any change of condition assessment related to R7's change of condition on 09/13/24 including physician notification, mode of transport, and destimation. The record lacked evidence the appropriate health information was communicated to the receiving provider or healthcare destination. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry Physician Progress Note dated 09/24/24 at 10:05 AM documented that R7 was admitted to the hospital on [DATE] after a seizure. R7 had bitten his tongue. R7 had a full seizure in the emergency room. R7 was discharged back to the facility on [DATE]. On 10/15/24 at 09:00 AM R7 lay on his bed with his blanket over his head. On 10/17/24 at 09:15 PM Administrative Nurse D stated that the nurses initiate the discharges and should complete a discharge summary in the EMR. Administrative Nurse D stated that she expected nursing staff to document any change in the condition of a resident including when a resident would need to be sent to the hospital. The facility did not provide a policy related to discharge preparation. The facility failed to ensure that R7's transfer or discharge was documented in the resident ' s medical record and appropriate information was communicated to the receiving healthcare institution or provider. This placed R7 at risk for delayed treatment and impaired continuity of care.

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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 Electronic Medical Record (EMR) for R44 documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary tract infection (UTI-an infection in any part of the urinary system), and lymphedema (swelling caused by accumulation of lymph fluid). The Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition and required substantial assistance from staff for eating, toileting, bathing, mobility, and transfers. R44 received insulin (medications used to help reduce the amount of sugar present in the blood) and diuretic (a medication to promote the formation and excretion of urine) medications. R44's Care Plan, dated 09/05/24, documented that R44 had the potential for fluid volume deficit and directed staff to instruct R44 and their family on the importance of fluid intake, monitor weight as ordered, observe urine output for signs of dehydration and strong odor. The care plan directed staff to check for incontinence during rounds, assist R44 as needed with the use of a bedpan, check and change with rounds, and establish voiding patterns. The care plan directed staff to obtain an Accu-check (blood glucose monitoring test) with sliding scale coverage as ordered, administer diabetes medication as physician ordered, dietary consult for nutritional regimen, and discuss with R44 the importance of compliance with dietary restrictions. The Progress Notes, dated 10/14/24 at 02:33 PM, documented that R44 was admitted to the hospital due to vomiting coffee grounds. R44's clinical record lacked evidence the resident was provided a written notice when she was transferred to the hospital. On 10/14/24 at 08:40 AM, observation revealed R44 was in bed and had a plastic bag on her lap, R44 stated she was nauseated and had vomited multiple days. R44 stated she had been given medication for the nausea and had thought that it was from the weight loss injections she had been given. R44 started to vomit into the plastic bag and this Surveyor went and got the nurse. On 10/17/24 at 10:00 AM Administrative Staff A stated that the facility did provide the Notice of Transfer/Discharge form to the ombudsman and the resident ' s representative would be called to be notified of the transfer, but the notice of transfer was not mailed to the representative that she was aware of. The facility's readmission to the Facility policy, dated 11/28/17, documented that residents who have been discharged to the hospital or for therapeutic leave will be given priority in readmission to the facility. At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident or the resident representative written notice specifying the duration of the bed-hold policy, and the opportunity to pay the bed-hold if allowed by the State Plan. At the time of admission, the resident or the resident representative will be provided with the facility's bed hold policy. The facility will provide the second notice of bed-hold at the time of transfer, or in cases of emergency transfer, within 24 hours. The facility will document the attempts to reach the resident's representative in situations where unable to notify the resident or representative. The facility notice will provide information that explains the duration of the bed-hold and the bed-hold (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	payment policy. Also, the notice will include permitting the return of residents to the next available bed. The facility failed to provide the resident or resident representative written notification of the facility-initiated transfer. This placed R44 at risk of impaired rights. The facility identified a census of 49 residents. The sample included 13 residents with three sampled residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide written notification of transfer to Resident (R) 33 and R44 or their representatives for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and impaired rights for R33 and R44. Findings included: - R33's Electronic Medical Record (EMR) documented diagnoses of fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), epilepsy (brain disorder characterized by repeated seizures), hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic respiratory failure with hypoxia (inadequate supply of oxygen), major depressive disorder (major mood disorder that causes persistent feelings of sadness), muscle wasting and atrophy, need for assistance with personal care, unsteady on feet and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Minimum Data Set (MDS), dated [DATE], documented a quarterly assessment and a discharge from the facility, with a return anticipated. The MDS, dated [DATE], documented an entry into the facility. The MDS, dated [DATE], documented a discharge with a return anticipated. The MDS, dated [DATE], documented an entry into the facility. The MDS, dated [DATE], documented a discharge with a return anticipated. The MDS, dated [DATE], documented an entry into the facility. The Progress Note dated 07/10/24 at 09:01 PM, documented a change in R33's condition. The primary care provider ordered the resident to be sent to the emergency room for evaluation and treatment. The Progress Note dated 07/12/24 at 01:55 PM documented R33 returned to the facility. The Progress Note dated 07/20/24 at 09:42 PM documented a change in R33's condition. The primary care provider ordered the resident to be sent to the emergency room for evaluation and treatment. The Progress Note dated 07/24/24 at 02:45 PM, documented R33 returned to the facility. The Progress Note dated 07/29/24 at 05:35 PM, documented R33 seen by the practitioner and was sent to the emergency room at a different hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admit/Readmit Screener, dated 08/02/24, recorded R33 readmitted to the facility. R33's clinical record lacked evidence the resident was provided a written notice when she was transferred to the hospital. The facility was unable to provide evidence as requested. On 10/15/24 at 09:44 AM, R33 was observed going outside to smoke with a jacket on. R33 was able to get in and out of the door unassisted. On 10/17/24 at 10:00 AM Administrative Staff A stated that the facility did provide the Notice of Transfer/Discharge form to the ombudsman and the resident ' s representative would be called to be notified of the transfer, but the notice of transfer was not mailed to the representative that she was aware of. The facility's readmission to the Facility policy, dated 11/28/17, documented that residents who have been discharged to the hospital or for therapeutic leave will be given priority in readmission to the facility. At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident or the resident representative written notice specifying the duration of the bed-hold policy, and the opportunity to pay the bed-hold if allowed by the State Plan. At the time of admission, the resident or the resident representative will be provided with the facility's bed hold policy. The facility will provide the second notice of bed-hold at the time of transfer, or in cases of emergency transfer, within 24 hours. The facility will document the attempts to reach the resident's representative in situations where unable to notify the resident or representative. The facility notice will provide information that explains the duration of the bed-hold and the bed-hold payment policy. Also, the notice will include permitting the return of residents to the next available bed. The facility failed to provide the resident or resident representative written notification of the facility-initiated transfer. This placed R33 at risk of impaired rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - The Electronic Medical Record (EMR) for R44 documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary tract infection (UTI-an infection in any part of the urinary system), and lymphedema (swelling caused by accumulation of lymph fluid). The Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition and required substantial assistance from staff for eating, toileting, bathing, mobility, and transfers. R44 received insulin (medications used to help reduce the amount of sugar present in the blood) and diuretic (a medication to promote the formation and excretion of urine) medications. R44's Care Plan, dated 09/05/24, documented that R44 had the potential for fluid volume deficit and directed staff to instruct R44 and their family on the importance of fluid intake, monitor weight as ordered, observe urine output for signs of dehydration and strong odor. The care plan directed staff to check for incontinence during rounds, assist R44 as needed with the use of a bedpan, check and change with rounds, and establish voiding patterns. The care plan directed staff to obtain an Accu-check (blood glucose monitoring test) with sliding scale coverage as ordered, administer diabetes medication as physician ordered, dietary consult for nutritional regimen, and discuss with R44 the importance of compliance with dietary restrictions. The Progress Notes, dated 10/14/24 at 02:33 PM, documented that R44 was admitted to the hospital due to vomiting coffee grounds. R44's clinical record lacked evidence the resident and/or representative received a copy of the bed hold notice at the time of transfer or discharge. The facility was unable to provide evidence as requested. On 10/14/24 at 08:40 AM, observation revealed R44 was in bed and had a plastic bag on her lap, R44 stated she was nauseated and had vomited multiple days. R44 stated she had been given medication for the nausea and had thought that it was from the weight loss injections she had been given. R44 started to vomit into the plastic bag and this Surveyor went and got the nurse. On 10/15/24 at 02:20 PM, Administrative Staff A stated she had not discussed bed hold with the family but would call them at some point, fill out discharge paperwork, and put it into R44's file. The facility's readmission to the Facility policy, dated 11/28/17, documented that residents who have been discharged to the hospital or for therapeutic leave will be given priority in readmission to the facility. At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident or the resident representative written notice specifying the duration of the bed-hold policy, and the opportunity to pay the bed-hold if allowed by the State Plan. At the time of admission, the resident or the resident representative will be provided with the facility's bed hold policy. The facility will provide the second notice of bed-hold at the time of transfer, or in cases of emergency transfer, within 24 hours. The facility will document the attempts to reach the resident's representative in situations where unable to notify the resident or representative. The facility notice will provide information that explains the duration of the bed-hold and the bed-hold payment policy. Also, the notice will include permitting the return of residents to the next available (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. The facility failed to provide R44 with a bed hold notice which specifies the duration of the bed hold when she was transferred to the hospital. This placed R44 at risk of not being permitted to return and resume residence in the facility. The facility had a census of 49 residents. The sample included 13 residents of which three residents were reviewed for transfer and/or discharge. Based on record review and interview, the facility failed to provide Resident (R) 33 and R44 with the appropriate bed hold policy as required. This placed the residents at risk of being uninformed of bed-hold requirements. Findings included: - R33's Electronic Medical Record (EMR) documented diagnoses of fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), epilepsy (brain disorder characterized by repeated seizures), hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic respiratory failure with hypoxia (inadequate supply of oxygen), major depressive disorder (major mood disorder that causes persistent feelings of sadness), muscle wasting and atrophy, need for assistance with personal care, unsteady on feet and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Minimum Data Set (MDS), dated [DATE], documented a quarterly assessment and a discharge from the facility, with a return anticipated. The MDS, dated [DATE], documented an entry into the facility. The MDS, dated [DATE], documented a discharge with a return anticipated. The MDS, dated [DATE], documented an entry into the facility. The MDS, dated [DATE], documented a discharge with a return anticipated. The MDS, dated [DATE], documented an entry into the facility. The Progress Note dated 07/10/24 at 09:01 PM, documented a change in R33's condition. The primary care provider ordered the resident to be sent to the emergency room for evaluation and treatment. The Progress Note dated 07/12/24 at 01:55 PM documented R33 returned to the facility. The Progress Note dated 07/20/24 at 09:42 PM documented a change in R33's condition. The primary care provider ordered the resident to be sent to the emergency room for evaluation and treatment. The Progress Note dated 07/24/24 at 02:45 PM, documented R33 returned to the facility. The Progress Note dated 07/29/24 at 05:35 PM, documented R33 seen by the practitioner and was sent to the emergency room at a different hospital. The Admit/Readmit Screener, dated 08/02/24, recorded R33 readmitted to the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's clinical record lacked evidence the resident and/or representative received a copy of the bed hold notice at the time of transfer or discharge. The facility was unable to provide evidence as requested. On 10/15/24 at 09:44 AM, R33 was observed going outside to smoke with a jacket on. R33 was able to get in and out of the door unassisted. On 10/15/24 at 02:00 PM, Administrative Staff A stated that R33's representative was called related to the discharge of the resident at each discharge. Admin Staff A verified the facility had not provided the bed hold notice to R33's representative. The facility's readmission to the Facility policy, dated 11/28/17, documented that residents who have been discharged to the hospital or for therapeutic leave will be given priority in readmission to the facility. At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident or the resident representative written notice specifying the duration of the bed-hold policy, and the opportunity to pay the bed-hold if allowed by the State Plan. At the time of admission, the resident or the resident representative will be provided with the facility's bed hold policy. The facility will provide the second notice of bed-hold at the time of transfer, or in cases of emergency transfer, within 24 hours. The facility will document the attempts to reach the resident's representative in situations where unable to notify the resident or representative. The facility notice will provide information that explains the duration of the bed-hold and the bed-hold payment policy. Also, the notice will include permitting the return of residents to the next available bed. The facility failed to provide R33 with a bed-hold policy which placed the resident at risk of being uninformed choices and impaired ability to return to the same room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 49 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to accurately assess and document that Resident (R) 30 had a terminal condition on the Minimum Data Set (MDS) assessment. This placed the resident at risk for an inaccurate care plan and unmet care needs. Findings included: - The Electronic Medical Record (EMR) for R30 documented diagnoses of stomach cancer, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), heart failure, and hypertension (high blood pressure). The admission Minimum Data Set (MDS), dated [DATE], documented R30 had intact cognition and required set-up assistance with toileting, and upper body dressing. R30 was independent with personal hygiene, mobility, transfers, and ambulation. The MDS noted R30 had no behaviors and received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and antianxiety (a class of medications that calm and relax people) medication. The assessment lacked documentation R30 had a terminal condition and was on hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. R30's Care Plan, dated 08/14/24, initiated on 09/10/24, documented R30 had a terminal prognosis related to gastric (stomach) cancer and directed staff to consult with the physician to have hospice care for R30. The care plan documented encouraged R30 to express feelings, listen with non-judgmental acceptance, observe for signs of pain, administer pain medications as ordered, and notify the physician immediately if there was breakthrough pain. Staff were to refer to a psychiatric or psychologist consult if needed, review R30's living will and ensure it was followed, and work with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. The Nurse's Note, dated 08/19/24 at 08:32 PM, documented R30 was evaluated and admitted into hospice services. On 104/24 at 02:41 PM, observation revealed R30 sat in his wheelchair and had his head lying on his bed. On 10/17/24 at 12:1 PM, Administrative Nurse D stated MDS assessments were completed offsite. Administrative Nurse D said she would pass on the information to the person completing the MDS that R30 received hospice services and that it should have been on the MDS assessment. The facility's Resident Assessment Instruments policy, dated 12/10, documented a comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. The Assessment Coordinator was responsible for ensuring that the Interdisciplinary Assessment Team conducts timely resident assessments and reviews according to the following schedule. The purpose of the assessment was to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. Information derived from the comprehensive assessments helped the staff to plan care that allowed the resident to reach his/her highest practicable (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level of functioning. The facility failed to accurately assess and record R30's terminal condition on his 08/26/24 comprehensive MDS. This placed the resident at risk for an inaccurate care plan and unmet care needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 49 residents. The sample had 13 residents, with four reviewed for bathing. Based on observation record review, and interview, the facility failed to provide consistent bathing for fResident (R) 17, R24, R44, and R45. This placed the residents at risk for poor hygiene and related complications. Findings included: - The Electronic Medical Record (EMR) for R17 documented diagnoses of heart disease, a need or assistance with personal care, heart failure, atrial fibrillation (rapid, irregular heartbeat), and dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion). The Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented R17 had severely impaired cognition. R17 required substantial assistance with bathing, partial assistance with toileting, and partial assistance with toileting and dressing. The Quarterly MDS, dated 10/03/24, documented R17 had severely impaired cognition and required substantial assistance with bathing. R17's Care Plan, dated 09/27/24 and initiated on 04/12/24, documented that R17 required supervision assistance of one staff member for bathing, and directed staff to provide a bath per schedule, allow the resident time to complete tasks, and praise him for all his efforts made. The August 2024 Bathing Record documented R17 requested showers on Monday and Thursday dayshift and documented R17 had not received a bath or shower the following days: 08/01/14- 08/14/24 (14 days) 08/23/24- 08/31/24 (9 days) The EMR documented R17 refused a shower on 08/05/24, 08/26/24, and 08/29/24. The October 2024 Bathing Record documented R17 requested showers on Monday and Thursday dayshift and documented R17 had not received a bath or shower the following days: 10/01/24- 10/17/24 (17 days) The EMR documented R17 refused a shower on 10/03/24 and 10/10/24. On 10/15/25 at 08:41 AM, observation revealed R17 was unshaven and had dried liquid stains on his jeans. On 10/17/24 at 08:26 AM, Certified Nurse Aide (CNA) M stated when R17 refused his bath, staff documented the refusals on a shower sheet that was given to the Director of Nursing. CNA M stated that sometimes it took two staff to give R17 a shower. On 10/17/24 at 09:30 AM Licensed Nurse (LN) H stated R17 did refuse showers but staff tried to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	offer at different times and days. On 10/17/24 at 11:45 AM, Administrative Staff A stated the facility did use shower sheets along with documentation in the EMR but the shower sheets have been thrown away. The facility's Shower/Tub Bath policy, dated 10/09, documented that staff are to promote cleanliness, provide comfort to the resident, and observe the condition of the skin. After a resident received his or her shower, staff document the date and time the shower/tub was performed, who assisted the resident with the shower/bath, and if there were any reddened areas or sores. If the resident refused the shower/tub bath, staff document the reasons why and what interventions were initiated, Staff notify the supervisor, and report any other information in accordance with facility policy and professional standards taken. The facility failed to provide R17 with consistent bathing. This placed him at risk for poor hygiene. - The Electronic Medical Record (EMR) for R24 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type 2, hypertension (high blood pressure), and atrial fibrillation (rapid, irregular heartbeat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R24 had intact cognition. R24 required partial assistance with showers. R24's Care Plan, dated 08/29/24 and initiated on 11/24/23, documented R24 required limited staff participation with bathing. Staff were to inspect her skin for open areas and redness, assist the resident with clothing, and stand by assistance with transfers. The August 2024 Bathing Record documented R24 requested showers on Tuesday and Friday dayshift and documented R24 had not received a bath or shower the following days: 08/01/24- 08/26/24 (26 days) The EMR documented R24 refused a shower on 08/02/24, 08/06/24, and 08/20/24. The September 2024 Bathing Record documented R24 requested showers on Tuesday and Friday dayshift and documented R24 had not received a bath or shower the following days: 09/11/24- 09/30/24 (20 days) The EMR documented R24 refused a shower on 09/13/24, 09/17/24, and 09/20/24. The October 2024 Bathing Record documented R24 requested showers on Tuesday and Friday dayshift and documented R24 had not received a bath or shower the following days: 10/09/24-09/17/24 (9 days) On 10/14/24 at 10:50 AM, observation revealed R24's hair was disheveled and greasy. On 10/17/24 at 08:26 AM, Certified Nurse Aide (CNA) M stated if R24 refused her showers, staff (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented the refusals on a shower sheet that was given to the Director of Nursing. On 10/17/24 at 09:30 AM, Licensed Nurse (LN) H stated she was unsure whether R24 refused her showers but if she did, staff would inform the charge nurse and document it on the shower sheet which was turned in to administration. On 10/17/24 at 11:45 AM, Administrative Staff A stated the facility did use shower sheets along with documentation in the EMR but the shower sheets have been thrown away. The facility's Shower/Tub Bath policy, dated 10/09, documented that staff are to promote cleanliness, provide comfort to the resident, and observe the condition of the skin. After a resident received his or her shower, staff document the date and time the shower/tub was performed, who assisted the resident with the shower/bath, and if there were any reddened areas or sores. If the resident refused the shower/tub bath, staff document the reasons why and what interventions were initiated, Staff notify the supervisor, and report any other information in accordance with facility policy and professional standards taken. The facility failed to provide R24 with consistent bathing. This placed her at risk for poor hygiene. - The Electronic Medical Record (EMR) for R44 documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary tract infection (UTI-an infection in any part of the urinary system), and lymphedema (swelling caused by accumulation of lymph fluid). The Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition. R44 required substantial assistance from staff for eating, toileting, bathing, mobility, and transfers. R44's Care Plan, dated 09/05/24, directed staff to assist R44 with bathing and provide her bath as scheduled. The care plan directed staff to provide assistance with dressing and getting garments from the closet or drawer and praise residents for all efforts made. The September 2024 Bathing Record documented R44 received daily bed baths and documented R44 had not received a bed bath or shower the following days: 09/22/24- 09/30/24 (9 days) The EMR lacked documentation R44 refused any baths or showers. The October 2024 Bathing Record documented R44 received bed baths and documented R44 had not received a bed bath or shower the following days: 10/03/24- 10/09/24 (7 days) The EMR lacked documentation R44 refused any baths or showers. On 10/14/24 at 08:40 AM, observation revealed R44 sat up in bed, and her hair was disheveled. R44 reported she was nauseated and had vomited several times in the past few days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/17/24 at 08:55 AM, Certified Nurse Aide (CNA) M stated R44 did not refuse the bed bath or shower and she could decide which one she wanted. On 10/17/24 at 09:30 AM Licensed Nurse (LN) H stated she was unsure if R44 refused her showers but if she did, staff would inform the charge nurse and document it on the shower sheet which was turned in to administration. On 10/17/24 at 11:45 AM, Administrative Staff A stated the facility did use shower sheets along with documentation in the EMR but the shower sheets have been thrown away. The facility's Shower/Tub Bath policy, dated 10/09, documented that staff are to promote cleanliness, provide comfort to the resident, and observe the condition of the skin. After a resident received his or her shower, staff document the date and time the shower/tub was performed, who assisted the resident with the shower/bath, and if there were any reddened areas or sores. If the resident refused the shower/tub bath, staff document the reasons why and what interventions were initiated, Staff notify the supervisor, and report any other information in accordance with facility policy and professional standards taken. The facility failed to provide R44 with consistent bathing. This placed her at risk for poor hygiene. - R45's Electronic Medical Record (EMR) documented diagnoses of acute respiratory failure with hypoxia (inadequate supply of oxygen), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), altered mental status, chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), other mechanical complication of cystostomy catheter (urinary bladder catheter inserted through the abdomen into the bladder), urinary tract infection, obstructive and reflux uropathy (disorder or urinary tract), a disorder of bone density and structure, muscle weakness, and lack of coordination. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R45 had intact cognition, exhibited no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or behaviors. R45 was dependent on toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R45 required partial/moderate assistance with upper body dressing, and substantial/maximal assistance with personal hygiene, bed mobility, standing, and transfers. The MDS further documented R45 had an indwelling catheter and was always incontinent of bowel. R45 received as-needed pain medication and had pain that occasionally affected sleep, day-to-day activities, and therapy. R45 had shortness of breath with exertion and lying flat, had oxygen therapy, a non-invasive mechanical ventilator, and speech, occupational, physical, and respiratory therapy. R45 had surgical wound care and received an antidepressant (a class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain). R45's Care Plan dated 09/05/24, documented the resident exhibited activities of daily living (ADL) self-care performance deficit and required assistance of substantial to maximal assistance due to limited mobility. The plan documented that R45 required substantial to maximal assistance of one staff for bathing, toileting, and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Note dated 09/07/24 at 01:42 PM, documented that R45 had been readmitted to the facility with a diagnosis of right hip fracture, weight bearing as tolerated; R45 used a wheelchair for mobility propelled by staff. A review of R45's EMR revealed R45 had not received bathing for a 27-day period between September 2024 and October 15, 2024. On 10/15/24 at 02:04 PM, observation revealed R45 sat in a wheelchair in her room, working with yarn and a crochet hook. Certified Nurse Aide (CNA) N was present in the room and reported this to be the third day she worked at the facility; she said she was not aware of the bathing schedule for R45. On 10/17/24 at 02:55 PM, Administrative Nurse D reported staffing a bath aide to complete bathing and the facility had been documenting bathes on paper to monitor bathing schedules, but the bathing records had been thrown away and not recorded in the EMR. Administrative Nurse D stated residents should be bathed more frequently than every 27 days. The facility's Shower/Tub Bath policy, dated 10/09, documented that staff are to promote cleanliness, provide comfort to the resident, and observe the condition of the skin. After a resident received his or her shower, staff document the date and time the shower/tub was performed, who assisted the resident with the shower/bath, and if there were any reddened areas or sores. If the resident refused the shower/tub bath, staff document the reasons why and what interventions were initiated, Staff notify the supervisor, and report any other information in accordance with facility policy and professional standards taken. The facility filed to provide R45 assistance with bathing, which placed the resident at risk for poor hygiene.

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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** - The Electronic Medical Record (EMR) for R43 documented diagnoses of traumatic brain injury (TBI-an injury to the brain caused by external forces), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), abnormalities of gait and mobility, mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time) and localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The admission Minimum Data Set (MDS), dated [DATE], documented R43 had moderately impaired cognition. R43 was dependent on staff for toileting, bathing, dressing, and personal hygiene and required substantial assistance for mobility and transfers. The MDS documented R43 had functional impairment on both lower extremities. R43 had an unhealed Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer and had a pressure relieving device for her chair and received pressure ulcer dressings. The Braden Scale Assessment, (a formal assessment for predicting pressure ulcer risk) dated 10/01/24 documented that R43 was at low risk for breakdown. The assessments dated 10/08/24 and 10/15/24 documented R43 had no risk for skin breakdown. R43's Interim Care Plan, dated 10/01/24, directed staff to provide R43 with a pressure device for her bed and chair, inspect her skin according to facility protocol, treat the pressure ulcer according to the physician's orders, and document. R43's Care Plan, dated 10/14/24, documented R43 had a Stage 2 pressure injury to her right buttock (either of the two round fleshy parts that form the lower rear area of a human trunk) and directed staff to administer treatment as ordered and monitor effectiveness. The plan directed staff to check for incontinence during rounds and provide care as needed, document wound appearance, color, wound healing, signs and symptoms of infection, and wound size. The care plan directed staff to keep the bed as flat as tolerated to reduce shear, notify the family of any new area of skin breakdown, notify the nurse of any new areas of breakdown, obtain lab and diagnostic work as ordered, and report the results to the physician and follow-up as needed. Staff were to provide wound healing supplements as ordered, refer to the dietician to follow recommendations, and serve R43's diet as ordered. The Physician's Order, dated 10/01/24, directed staff to cleanse the wound to the right buttock with wound cleanser, pat it dry with a 4 x 4 gauze pad, apply Medihoney (medical-grade honey used to aid wound healing) to the wound bed, nickel thick, and cover with a dry dressing every three days on day shift. This order was discontinued on 10/10/24. The Physician's Order, dated 10/10/24, directed staff to cleanse the wound to the right buttock with wound cleanser, pat it dry with a 4 x 4, apply Medihoney to the wound bed, nickel thick, and cover with a dry dressing every Monday, Wednesday, and Friday. The Weekly Skin Review, dated 10/01/24, documented R43 had a Stage 2 pressure injury on her right buttock that measured 4.1 centimeters (cm) x 6.2 cm x 0.1 cm. The Weekly Skin Review, dated 10/10/24, documented R43 had a Stage 2 pressure injury on her right buttock that measured 4.1 cm x 6.2 cm x 0.1 cm. The wound had 100 percent (%) slough (dead tissue, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually cream or yellow), had shown no improvement, and documented an appointment with the wound clinic would be scheduled. The Nurse's Note, dated 10/16/24, documented R43's right buttock wound measured 3.3 cm x 2.6 cm x less than 0.1 cm and documented the wound was yellow-greenish in color. R43's clinical record lacked evidence there the Registered Dietician evaluated R43's nutritional status to promote wound healing. On 10/14/24 at 02:44 PM, observation revealed that R43's room contained a bed and no other chair or recliner. R43 sat in her wheelchair in her room. Observation revealed there was no cushion in her wheelchair. On 10/15/24 at 09:00 AM, observation revealed R43 sat in her wheelchair in her room with no cushion in her wheelchair. On 10/15/24 at 09:16 AM, Certified Nurse Aide (CNA) O pushed R43 into the bathroom, donned clean gloves but not a gown, assisted R43 to stand up, and pulled down R43's pants. CNA O pulled off part of the dressing that was on R43's right buttock wound. The wound bed was yellow, with redness to the skin surrounding the wound and there was no drainage apparent. On 10/17/24 at 08:25 AM, CNA M stated R43 sat in her wheelchair most of the time. CNA M did not remember R43 ever having had a cushion in her wheelchair. On 10/15/24 at 10:29 AM, Administrative Nurse D stated R43 should have a cushion in her wheelchair and verified R43 had not had a nutritional assessment completed with recommendations from the Registered Dietician. Administrative Nurse D verified there were no supplements for wound healing ordered for R43. Administrative Nurse D stated she would contact the physician and dietician to obtain orders for R43. The facility's Prevention of Pressure Ulcers policy, dated 03/2005, directed staff to review the resident's care plan to assess for any special needs of the resident and see the policy and procedure for specific tasks such as bathing, incontinence care, and repositioning. Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident. The facility should have a system/procedure to ensure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. Identify risk factors for pressure ulcer development, for a person in a chair change position at least every hour, and use foam, gel, or air cushion as indicated to relieve pressure. The Dietitian would assess nutrition and hydration and make recommendations based on the individual resident's assessment. The facility failed to provide a pressure-reducing wheelchair cushion and nutritional support to promote healing for R43 who had a Stage 2 pressure ulcer upon admission. This placed R43 at risk for further breakdown and delayed healing. The facility identified a census of 49 residents. The sample included 13 residents with two (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents reviewed for treatment of 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 ensure Resident (R) 7 received appropriate prompt treatment to promote healing and prevent worsening of a Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcers. The facility also failed to ensure R43 had nutritional measures and a pressure reducing device for her wheelchair in place. This placed R7 and R43 at risk for delayed healing and or increased risk for pressure ulcers. Findings included: - The electronic medical record (EMR) for R7 documented diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), respiratory failure (a condition where your blood does not have enough oxygen), dysphagia (swallowing difficulty), aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit), Stage 2 pressure wound, and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R7's Entry Minimum Data Set (MDS) dated 09/19/24 documented a reentry after a short-term acute hospital stay. R7's Significant Change MDS, dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R7 had a swallowing disorder and required a feeding tube for nutrition. R7 was at risk of pressure ulcers. R7's Significant Change MDS lacked documentation that R7 had a Stage 2 pressure ulcer. R7's Nutritional Care Area Assessment (CAA) dated 10/01/24 documented he had a potential nutrition risk related to a medical history of cerebral infarction, dysphagia, and COPD and received nothing by mouth (NPO); he was dependent on enteral nutrition support to meet all estimated nutrient needs. R7's Care Plan last revised on 10/14/24 documented he had the potential for pressure ulcer development and directed staff to do weekly skin assessments. Staff was directed to assist with turning and repositioning during rounds. R7 had a Stage 2 pressure injury to the left buttock. Staff was directed to administer treatments as ordered and monitor their effectiveness. Staff was directed to document wound appearance, color, wound healing, wound size, and stage. Staff was directed to provide a pressure relieving device in his bed. A Physician Progress Note dated 09/24/24 documented R7 was seen for re-admit after hospitalization. R7 was admitted to the hospital on [DATE] after a seizure (violent involuntary series of contractions of a group of muscles). He had a diagnosis of a pressure injury of the right heel, left buttock, and sacral (large triangular bone/area between the two hip bones) region Stage 2 that was added on 09/17/24. R7 was discharged back to the facility on [DATE]. A physical exam of the skin revealed R7's skin was warm and dry but did not include further documentation or examination of R7's sacral wound. A Weekly Skin Review Report dated 09/28/24 documented four Stage 2 pressure wounds to R7's left buttock. Wound One measured 1.2 centimeters (cm) in length by 1.0 cm in width; Wound Two measured 2.2 cm in length by a 1.5 cm width; Wound Three measured 0.7 cm in length by 0.3 cm in width; and Wound (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tanglewood Nursing & Rehabilitation	5015 SW 28th Street Topeka, KS 66614

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Four measured 0.4 cm length by 0.1 cm width. The wound beds were red with scant exudate (a fluid that leaks out of body vessels and tissues). A pressure-relieving device was in place (low air loss mattress). The primary provider and resident's responsible party were notified. A Physician Progress Note dated 10/03/24 documented R7 was seen for a new wound, R7 had a coccyx (tailbone the last bone at the base of your spine) wound that staff found yesterday. R7 also has a new wound on his right heel. Examination revealed a shallow ulcer in the coccyx, and the wound bed was beefy red. The diagnosis and orders for this visit include Stage 2 pressure ulcer of the coccyx region. The plan is to clean the coccyx wound with wound cleanser and apply zinc oxide twice daily and as needed. Under the Orders tab of the EMR documented a physician order dated 10/03/24 for wound healing to clean with normal saline and apply zinc twice daily. R7's EMR lacked documentation for a wound treatment before the 10/03/24 order. On 10/15/24 at 01:30 PM, R7 lay on his bed with the cover over his head as staff entered his room and prepared him for his wound treatment. On 10/17/24 at 11:46 PM Administrative Nurse E stated via telephone that after R7 returned from the hospital she believed they got him the low air loss mattress and she believed a foam dressing was put in place. Administrative Nurse D stated she was not sure why there was a delay in R7 being treated for his pressure wounds after his return from the hospital. Administrative Nurse D stated that R7's physician had orders in place, and she assessed the wound weekly. The Prevention of Pressure Ulcers policy documented that once a pressure ulcer develops it could be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident. The facility should have a system to ensure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician, and family, and addressed. The facility failed to monitor and treat R7's Stage 2 pressure ulcer to his left buttocks promptly which resulted in a delay of treatment. This placed R7 at risk for complications related to skin breakdown and pressure ulcers.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - The Electronic Medical Record (EMR) for R17 documented diagnoses of heart disease, a need or assistance with personal care, heart failure, atrial fibrillation (rapid, irregular heartbeat), and dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion). The Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented R17 had severely impaired cognition. R17 required substantial assistance with bathing, partial assistance with toileting, and partial assistance with toileting and dressing. R17 received supervision with mobility, transfers, and ambulation. R17 had no behaviors or wandering and had no alarms. The Quarterly MDS, dated 10/03/24, documented R17 had severely impaired cognition. R17 required substantial assistance with bathing, partial assistance with toileting, and supervision with toileting and dressing. The MDS documented R17 was independent with mobility, transfers, and ambulation. R17 had no behaviors or wandering and had no alarms. The Elopement Risk Assessments, dated 04/01/24, 06/07/24, and 09/07/24, documented R17 was at risk for elopement. R17's Care Plan, dated 09/27/24 and initiated on 06/07/24, documented R17 was an elopement risk and wanderer due to his dementia and directed staff to distract R17 from wandering by offering structured activities, food, conversation, television, and books. R17 was provided with a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) alert bracelet. The Physician's Order, dated 06/07/24, directed staff to check R17's WanderGuard for proper functioning daily, check for proper placement on the right wrist every shift, and replace the WanderGuard as needed upon expiration or not working properly. A review of the R17's Treatment Administration Record TAR including the October 2024 TAR showed staff documented they assessed R17's WanderGuard for placement and function every shift. The Nurses Notes, dated 10/09/2 at 04:26 AM, documented R17 refused to go to sleep and continued to set off door alarms. R17 walked up and down hallways unsafely and was combative with staff. On 10/15/24 at 08:41 AM, observation revealed R17 sat in his recliner taking his medication. Further observation revealed R17 did not have a WanderGuard alert bracelet on. Certified Medication Aide (CMA) R verified R17 did not have a WanderGuard bracelet on and stated she did not know what happened to it. On 10/15/24 at 09:00 AM, Administrative Nurse D stated that R17's family had requested the bracelet be taken off but Administrative Nurse D could not provide documentation for the request. She stated she would have another WanderGuard bracelet put on the resident. On 10/15/24 at 02:30 PM, Licensed Nurse (LN) G stated staff checked R17's WanderGuard every shift for placement. LN G did not know how long R17 had not had his WanderGuard on. The facility's Problematic Behavior Management policy dated 12/08, documented as part of the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	initial assessment, the staff and physician would identify individuals with a history of impaired cognition, problematic behavior, or mental illness. Nursing staff would document the nature, duration, and associated features of any changes over time in behavior, cognition, or mood and notify the physician. The facility failed to ensure R17's WanderGuard was in place and functioning. These deficient practices placed the resident at risk of accidents and related injuries. The facility had a census of 49 residents. The sample included 13 residents of which seven were reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure fall prevention interventions, including a floor mat, were utilized for Resident (R) 45. R45 subsequently had a fall, which resulted in a right femur non-displaced femoral (thigh bone) neck fracture. The facility further failed to ensure R17's WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) was in place and functioning. These deficient practices placed the resident at risk of accidents and related injuries. Finding included: - R45's Electronic Medical Record (EMR) documented diagnoses of acute respiratory failure with hypoxia (inadequate supply of oxygen), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), altered mental status, chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), other mechanical complication of cystostomy catheter (urinary bladder catheter inserted through the abdomen into the bladder), urinary tract infection, obstructive and reflux uropathy (disorder or urinary tract), a disorder of bone density and structure, muscle weakness, and lack of coordination. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R45 had intact cognition, exhibited no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or behaviors. R45 was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R45 required partial/moderate assistance with upper body dressing, and substantial/maximal assistance with personal hygiene, bed mobility, standing, and transfers. The MDS further documented R45 had an indwelling catheter and was always incontinent of bowel. R45 received as needed pain medication and had pain that occasionally affected sleep, day-to-day activities, and therapy. R45 had shortness of breath with exertion and lying flat, had oxygen therapy, a non-invasive mechanical ventilator, and speech, occupational, physical, and respiratory therapy. R45 had surgical wound care and received an antidepressant (a class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain) medications in the look back period. R45's Care Plan, dated 07/08/24, documented R45 was at risk for falls related to incontinence. The care plan directed staff to anticipate and meet R45's needs and be sure her call light was within reach. The plan encouraged the resident to use the call light for assistance as needed, directed staff to respond promptly to all requests for assistance, and ensure a safe environment with floors free from spills and clutter, ensure adequate light, ensure the bed in a low position, and ensure personal items were within reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note, dated 07/21/24 at 10:18 AM, documented at 06:15 AM, R45 was yelling and found on her left side, next to her low bed, with her oxygen off. She had blood all over her face and on the ground. It looked like she hit her face on the oxygen concentrator. A towel was placed on the resident's face and vital signs were assessed. Staff called 911 and sent R45 to the hospital. The note further documented that R45's responsible party was notified and the representative asked that a thick pad be placed on the floor. R45's Care Plan documented R45 had a fall on 07/21/24, which resulted in an emergency room transfer for a laceration to the bridge of her nose and required five sutures. The Progress Note dated 07/29/24 at 07:02 PM, documented on 07/27/24 at approximately 06:00 AM, R45 was yelling to get up. The staff informed the resident that help was not available at that time, and they would get more help and then assist the resident to get up. Staff observed R45 scooting onto the floor mat (mattress). The note further documented the writer thought the mattress was care planned but was told it was not. R45's Care Plan documented R45 had a noninjury fall on 07/29/24. A revision dated 07/29/24 directed staff that R45's preference was to get up early in the morning. The Progress Note, dated 08/30/24 at 04:32 AM, documented at approximately 04:00 AM R45 was heard yelling for help. The resident was found lying on her right side. Staff assisted the resident back to bed. Staff notified the responsible party, the Director of Nursing, and the resident's physician. The Progress Note dated 08/30/24 at 08:53 AM, documented staff called R45's responsible party regarding the representative's concerns, and the representative was upset that R45 had fallen from bed. Facility staff assured R45's responsible party the facility would be looking into the fall and placing interventions to prevent future falls and injuries. The Progress Note dated 08/30/24 at 03:06 PM, documented X-ray results showing a right femur non-displaced femoral (thigh bone) neck fracture with angulation at the fracture site. Staff notified the physician and received orders to send R45 to the hospital. On 08/30/24 a Teachable Moment form was used to educate staff to follow the resident's plan of care and fall prevention interventions. The form documented that R45 had a fall, and the fall mat was not in place, leaving a large chance for preventable injuries. A report was made to the State Agency and the facility initiated an investigation into the fall. R45's Care Plan dated 08/30/24, documented R45 fell on [DATE] and the facility provided an in-service to staff to educate them on the need to follow all safety interventions. The care plan further documented the facility changed the fall mat out for a regular mattress next to the bed to reduce the distance if R45 crawled out of bed. The Progress Note dated 09/03/24 at 01:50 PM, documented the facility changed out the resident's fall mat for a full-size mattress, which would decrease the distance that R45 would fall from bed as the facility could not keep R45 from attempting to get up. R45's responsible party stated understanding of the new intervention and agreed with the choice. The Progress Note dated 09/04/24 at 01:42 PM documented R45 readmitted to the facility with a diagnosis of a right hip fracture, R45 was weight bearing as tolerated, and had a surgical incision to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the right thigh with nine staples and pain management in place. On 10/15/24 at 02:04 PM an observation revealed R45 sat in her room in a wheelchair. A mattress leaned up against the wall. R45 was working with yarn and a crochet hook. Certified Nurse Aide (CNA) N reported R45 did not lay down during the day, due to breathing issues. CNA N stated the mattress in the room against the wall was to be placed by the bed if the resident wanted to lie down. CNA N reported that R45 was usually up in the wheelchair when she arrived at work in the mornings. On 10/15/24 at 03:31 PM Administrative Staff A reported the facility completed a root cause analysis related to R45's falls, which resulted in the use of a full-sized mattress next to the bed and ensuring the bed was in a low position when the resident was in bed. Administrative Staff A stated staff received in-service regarding safety measures, which needed to be present and implemented. Administrative Staff A provided an investigation for the incident reported to the State Agency. The facility's Fall Clinical Protocol, dated 04/2007, documented as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of serious consequences of falling. If interventions have been successful in preventing falls, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention has been resolved. The facility failed to implement safety interventions for R45 related to falls. Subsequently, R45 fell which resulted in a femoral fracture. This also placed the resident at risk for future falls and injuries.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 49 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 45 with sanitary indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) care. This placed the resident at risk for urinary tract infections (UTI-an infection in any part of the urinary system) and other catheter-related complications. Findings included: - R45's Electronic Medical Record (EMR) documented diagnoses of acute respiratory failure with hypoxia (inadequate supply of oxygen), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), altered mental status, chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), other mechanical complication of cystostomy catheter (urinary bladder catheter inserted through the abdomen into the bladder), urinary tract infection, obstructive and reflux uropathy (disorder or urinary tract), a disorder of bone density and structure, muscle weakness, and lack of coordination. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R45 had intact cognition, exhibited no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or behaviors. R45 was dependent on toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R45 required partial/moderate assistance with upper body dressing, and substantial/maximal assistance with personal hygiene, bed mobility, standing, and transfers. The MDS further documented R45 had an indwelling catheter and was always incontinent of bowel. R45 received as-needed pain medication and had pain that occasionally affected sleep, day-to-day activities, and therapy. R45 had shortness of breath with exertion and lying flat, had oxygen therapy, a non-invasive mechanical ventilator, and speech, occupational, physical, and respiratory therapy. R45 had surgical wound care and received an antidepressant (a class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain). R45's Care Plan dated 07/08/24, documented an indwelling catheter for obstructive uropathy. The plan directed staff to change the catheter as ordered, check for patency and urinary output each shift, observe for pain and discomfort due to the catheter, observe and report signs and symptoms to the physician, and position the catheter bag and tubing below the level of the bladder. The Physician Orders dated 09/04/24, documented R45 had an indwelling catheter size 16 French (FR) with 10 cubic centimeters (cc) balloon to bedside drainage; provide catheter care every shift and as needed, and record catheter output every shift. The Progress Note dated 09/25/24 at 10:49 PM, documented the nurse placed a urinary catheter which remained in place, and draining. R45 had no concerns, complaints, pain, or discomfort at that time. The Progress Note dated 10/07/24 at 02:18 PM, documented that R45's family member thought R45 may had a UTI and the physician was notified. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 10/10/24 at 01:28 PM, documented R45 was seen by the physician who ordered phenazopyridine (a medication used to relieve symptoms caused by UTIs) 200 milligrams (mg) three times a day for three days and Gemtesa 75 mg (a medication used to treat overactive bladder) daily. On 10/15/24 at 02:04 PM, observation revealed Certified Nurse Aide (CNA) N providing catheter emptying task. CNA N explained to R45 that she was going to empty the catheter bag. CNA N placed gloves on and retrieved the measuring cylinder from the bathroom, gathered an incontinent wipe from a package on the overbed table, unhooked the drainage bag from the underside of the resident's wheelchair, drained the collection bag, wiped the drainage spicket with an incontinent wipe, then laid the drainage bag directly on the floor, smoothed it out flat, then placed the drainage back to the underside of the wheelchair. On 10/17/24 at 09:04 AM Licensed Nurse (LN) H stated CNA N should not have placed the catheter bag directly on the floor. On 10/17/24 at 03:00 PM, Administrative Nurse D reported catheter bags should not be laid directly on the ground. The facility's Urinary Catheter Care dated 03/31/16, documented the purpose of this procedure is to prevent catheter-associated urinary tract infections. Use standard precautions when handling or manipulating the drainage system. Be sure the catheter tubing and drainage bag are kept off the floor. The facility failed to provide R45 with sanitary indwelling urinary catheter care which placed the resident at risk for urinary tract infections.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 49 residents. The sample included 13 residents with one resident reviewed for enteral feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube) management. Based on observation, record review, and interview the facility failed to ensure that Resident (R) 7 had a flush order for pre and post-bolus (a method of tube feeding that involves giving a patient a large amount of liquid formula through a feeding tube all at once) via gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). This placed R7 at risk of G-tube complications and adverse reactions including dehydration (not enough fluids) and fluid overload. Findings included: - The electronic medical record (EMR) for R7 documented diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), respiratory failure (a condition where your blood does not have enough oxygen), dysphagia (swallowing difficulty), aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R7's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R7 had a swallowing disorder and required a feeding tube for nutrition. R7 was at risk of 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). R7's Nutritional Care Area Assessment (CAA) dated 10/01/24 documented he had a potential nutrition risk related to a medical history of cerebral infarction, dysphagia, and COPD and received nothing by mouth (NPO); he was dependent on enteral nutrition support to meet all estimated nutrient needs. R7's Care Plan last revised 08/08/24, directed staff to flush the G-tube with 150 cubic centimeters (cc) of water before and after feedings four times a day for water flush. R7's Orders tab of the EMR documented an order dated 05/08/24 for a G-tube flush with 150 cc of water four times a day. This order was discontinued on 09/19/24. R7's Order Summary Report documented an order dated 09/19/24 for a bolus of Glucerna (a nutritional supplement with low carbohydrate content) 1.5 to give 250 milliliters (ml) one time a day for supplement. R7's Order Summary Report documented an order dated 09/19/24 for G-tube a bolus of Glucerna 1.5 to give 250 ml two times a day for a supplement. R7's Order Summary Report documented an order dated 09/19/24 for G-tube a bolus of Glucerna 1.5 to give 250 ml at bedtime for a supplement. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Order Summary Report documented an order dated 09/19/24 for G-tube flush with 250 ml of water every day and night shift for a supplement. R7's Order Summary Report documented an order dated 09/19/24 for G-tube flush with 30 ml of water before and after meds and flush with 10 cc of water between each medication. R7's Orders tab lacked an order specifying the amount for G-tube flush prior to and after administration of the Glucerna bolus. On 10/15/24 at 01:30 PM, R7 lay on his bed. Licensed Nurse (LN) G knocked on his door and announced herself and stated she was going to be giving him his Glucerna. LN G flushed R7's G-tube with 150 ml of water prior to pouring the Glucerna into the syringe attached to the G-tube. LN G then poured the bolus of Glucerna into the syringe until all was emptied through the tube. LN G then poured an additional 30 cc of water into the tube to flush. On 10/15/24 at 01:45 PM LN G stated that R7's orders say to flush with 30 ccs of water before and after medications so she just assumed that was the amount that was to be used to flush the G-tube when giving the Glucerna. On 10/17/24 at 08:15 AM Administrative Nurse D stated that R7's G-tube should be flushed with 150 ml of water prior to and after his bolus of Glucerna. Administrative Nurse D stated the prior order must have been omitted upon his return from the hospital on [DATE]. The undated Enteral Nutrition policy documented that fluids to be provided beyond free fluid in the product would be calculated by the dietitian and referred to the physician for an order. The dietitian would recommend bolus fluid flushes, with consideration of the fluid content of the feeding product, resident weight, diagnosis, fluid, electrolyte, and nutritional status. The facility failed to ensure R7 had an order for a flush prior to and after administration of his enteral bolus feeding. This placed R7 at risk of G-tube complications and adverse effects including dehydration or fluid overload.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 49 residents. The sample included 13 residents, with three reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 30 had physician orders for oxygen therapy and failed to provide direction to staff for the cleaning, storage, and dispensing of oxygen. The facility failed to ensure R7 had a physician's order for his oxygen and further failed to store R7's and R45's respiratory equipment in a sanitary manner. This placed the residents at risk for increased respiratory infections and other related complications. Findings included: - The Electronic Medical Record (EMR) for R30 documented diagnoses of stomach cancer, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), heart failure, hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The admission Minimum Data Set (MDS), dated [DATE], documented R30 had intact cognition and required set-up assistance with toileting, and upper body dressing. R30 was independent with personal hygiene, mobility, transfers, and ambulation The MDS noted R30 had shortness of breath with exertion, resting, lying flat, and was on oxygen. R30's Care Plan, dated 08/14/24, documented R30 had oxygen therapy and directed staff to administer oxygen via nasal cannula at two liters continuously; observe for respiratory distress, and report to the physician as needed. R30's EMR lacked a physician order for the oxygen use. On 10/15/24 at 07:45 AM, observation revealed that R30's oxygen tubing and cannula were wrapped around an oxygen tank, unbagged. On 10/15/24 at 08:35 AM, R30 stated he used his oxygen every night and sometimes during the day. R30 stated when he used it during the day, he used an oxygen tank if he was out of his room. On 10/17/24 at 08:00 AM, observation revealed R30's oxygen tubing and cannula were wrapped around the back of the oxygen concentrator unbagged. On 10/15/24 at 08:52 AM, Administrative Nurse D verified R30 did not have a doctor's order for oxygen use. Administrative Nurse D said that when not in use, oxygen tubing and cannula are to be stored in a bag. On 10/17/24 at 08:28 AM, Certified Nurse Aide (CNA) M stated R30 wore his oxygen off and on, and stated when he did not have it on, the tubing should be stored in a bag. On 10/17/24 at 10:05 AM, Licensed Nurse (LN) H stated she did not think he used his oxygen but the tubing and cannula should be stored in a bag when not in use. The facility's Oxygen Use policy, dated 03/04, documented, for safe oxygen administration, verified (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that there was a physician's order for oxygen use, and reviewed the care plan for any special needs of the resident. Check the tubing connected to the oxygen cylinder to ensure that it is free of kinks, and turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. The facility failed to obtain physician orders prior to administering R30's supplemental oxygen and failed to store the oxygen tubing and cannula in a sanitary manner when not in use. This placed the resident at risk for respiratory complications and physical decline. - R45's Electronic Medical Record (EMR) documented diagnoses of acute respiratory failure with hypoxia (inadequate supply of oxygen), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), altered mental status, chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), other mechanical complication of cystostomy catheter (urinary bladder catheter inserted through the abdomen into the bladder), urinary tract infection, obstructive and reflux uropathy (disorder or urinary tract), a disorder of bone density and structure, muscle weakness, and lack of coordination. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R45 had intact cognition, exhibited no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or behaviors. R45 was dependent on toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R45 required partial/moderate assistance with upper body dressing, and substantial/maximal assistance with personal hygiene, bed mobility, standing, and transfers. The MDS further documented R45 had an indwelling catheter and was always incontinent of bowel. R45 received as-needed pain medication and had pain that occasionally affected sleep, day-to-day activities, and therapy. R45 had shortness of breath with exertion and lying flat, had oxygen therapy, a non-invasive mechanical ventilator, and speech, occupational, physical, and respiratory therapy. R45 had surgical wound care and received an antidepressant (a class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain). R45's Care Plan, dated 10/14/24, documented that R45 had oxygen therapy related to ineffective gas exchange. The plan noted that R45 removed the oxygen and continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep)at times, and at times did not want nebulizer treatments. The plan directed staff to observe R45 for signs and symptoms of respiratory distress and report to the physician. The oxygen setting for oxygen via nasal cannula/mask was at three liters continuously. The Physician Order, dated 09/08/24, directed staff to clean and label the bilevel positive airway pressure (BiPAP- a noninvasive ventilator that helps to breathe) and nebulizer masks, nasal cannula, tubing, filters, and water canisters weekly. On 10/15/24 at 11:32 AM, observation revealed R45 was not in her room, though the oxygen concentrator was on and set at two litters. The tubing was draped over the concentrator and the nasal cannula was lying on the floor behind the concentrator without a date or label. The nebulizer treatment equipment stored in a clear plastic bag had a date of 10/05/25. The CPAP mask and tubing lying on the bedside table were not covered and also lacked a date label. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 07:56 AM, observation revealed R45 in the dining room eating her meal. She wore oxygen per nasal cannula and had an oxygen canister on the back of the wheelchair. Observation of the R45's room revealed the oxygen tubing was draped over the top of the bed, over the pillow, and the nasal cannula lay on the bed. The date label remained 10/05/24. On 10/15/24 at 03:00 PM, Administrative Nurse D stated the oxygen tubing should be stored in a bag while not in use. Administrative Nurse D verified the oxygen equipment should be changed and labeled on a weekly basis. The facility's Oxygen Administration policy, dated 03/2004, lacked instructions related to changing and maintaining infection control practices of the oxygen and other equipment used. The facility failed to maintain, change, and label respiratory equipment for R45 which placed the resident at risk for respiratory infections. - The electronic medical record (EMR) for R7 documented diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), respiratory failure (a condition where your blood does not have enough oxygen), dysphagia (swallowing difficulty), aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R7's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R7 required moderate to maximal staff assistance with his functional abilities. R7 had a swallowing disorder and required a feeding tube for nutrition. R7 was at risk of 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). The MDS lacked documentation that R7 was on oxygen therapy. R7's Nutritional Care Area Assessment (CAA) dated 10/01/24 documented he had a potential nutrition risk related to a medical history of cerebral infarction, dysphagia, and COPD and received nothing by mouth (NPO); he was dependent on enteral nutrition support to meet all estimated nutrient needs. R7's Care Plan last revised on 10/14/24 directed staff to give nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) treatment and oxygen therapy as ordered. The care plan lacked staff direction for care and storage of the nebulizer and oxygen therapy equipment. A review of R7's Order Summary Report dated 10/17/24 revealed an order dated 09/19/24 for albuterol sulfate (a class of medication used to prevent and treat wheezing and shortness of breath caused by breathing problems inhalation nebulization solution one vial four times a day for shortness of air. R7's Order Summary Report lacked a physician's order for oxygen therapy. R7's Treatment Administration Record (TAR) lacked directions for staff to clean or change the nebulizer and oxygen tubing and how frequently. On 10/15/24 at 01:30 PM R7's laid in bed, his nebulizer mask and tubing laid on top of the table (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stand. The nebulizer tubing was dated 10/05/24. R7's supplemental oxygen machine was turned on and his nasal cannula (a device that delivers extra oxygen through a tube and into your nose) was lying on his bed. On 10/15/24 at 01:40 PM, Licensed Nurse (LN) G stated the tubing and mask should be placed in a plastic bag when not in use. LN G stated she believed that the tubing was changed out weekly on Sundays by the night shift staff. On 10/17/24 at 08:15 AM Administrative Nurse D stated all residents that received oxygen should have a physician's order for use. Administrative Nurse D stated the new masks and tubing should be changed out every Sunday night by staff. Administrative Nurse D stated the tubing and masks or cannulas should be stored in a dated bag when not in use. The Oxygen Administration policy documented: Verify that there was a physician's order for this procedure. Review the physician's order for facility protocol for oxygen administration. Document the following information in the resident's medical record: the date and time, the rate of oxygen flow, the route, and the rationale. The facility failed to ensure R7 had a physician's order in place for supplemental oxygen use. The facility failed to ensure staff appropriately changed, stored, and labeled R7's nebulizer mask, oxygen tubing, and cannula when not in use. This placed R7 at risk of respiratory complications and infection.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. The facility identified a census of 49 residents. The sample included 13 residents with Resident (R) 19 reviewed for pain management. Based on observation, record review, and interview, the facility failed to ensure R19 had her physician ordered Norco (a combination pain medication of opioid pain reliever hydrocodone and non-opioid pain reliever acetaminophen) medication available for administration as scheduled for pain management, which resulted in R19 missing a scheduled dialysis (a procedure where impurities or wastes are removed from the blood) appointment. This placed R19 at risk of complications related to unmanaged pain. Findings included: - R19's Electronic Medical Record (EMR) documented diagnosis of hypertension (HTN- elevated blood pressure), end-stage renal disease (ESRD-a terminal disease of the kidneys), and type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R19's Annual Minimum Data Set (MDS) dated 07/05/24 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R19 utilized a wheelchair for mobility and required moderate to maximal assistance from staff for functional abilities. R19 took pain medications for pain management. R19 was on dialysis. R19's Skin Care Area Assessment (CAA) dated 07/07/24 documented she had the potential for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as result of pressure, or pressure in combination with shear and/or friction) development related to immobility, incontinence, and ESRD. R19's Care Plan last revised on 07/07/24 directed staff to administer medications as directed. R19's Orders tab of the EMR documented a physician's order dated 09/17/24 for Norco tablet 10-325 milligrams (mg) one tablet by mouth three times daily for pain. A review of R19's October 2024 Medication Administration Record (MAR) revealed on 10/13/24 at 11:00 PM the Norco was unavailable for administration. On 10/15/24 at 08:03 AM R19 stated that she had missed her dialysis appointment yesterday (10/14/24) due to her being in pain and that her Norco pain medication had not been available for almost 24 hours. R19 stated she did not receive her Norco on Sunday 10/13/24 at 05:00 PM or at 11:00 PM. R19 stated the nurse had told her that the Norco had been ordered before the weekend but had not been received yet. On 10/15/24 at 08:05 AM Licensed Nurse (LN) G stated that the facility had ordered R19's pain medication, but it had not been received by the pharmacy until last night. LN G stated the facility did have an emergency kit, but as an agency nurse, she did not have access to the kit. On 10/17/24 at 08:15 AM Administrative Nurse D stated that the facility had been having some issues with the pharmacy service saying they had not received a refill request so there had been a delay. Administrative Nurse D stated that the medication aides and nurses have all been educated on ensuring that pain medication was sent for refill request five days prior to running out. Administrative (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse D stated that the facility also had an emergency kit for medications in the medication room, the nurse or medication aide would just have to call her or the assistant director of nursing (ADON) when a medication was needed. The Pain - Clinical Protocol policy documented: The physician and staff will identify individuals who have pain or who are at risk for having pain. This included a review of each person's known diagnoses and conditions that commonly cause or predispose to pain; It also included a review of any treatments that the resident currently was receiving for pain, including complementary (non-pharmacologic) treatments. The nursing staff would assess each individual for pain upon admission to the facility, at the quarterly review, whenever there was a significant change in condition, and when there was an onset of new pain or worsening of existing pain. The staff and physician would identify the nature and severity of the pain. Staff will assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. The staff would observe the resident (during rest and movement) for evidence of pain. The facility failed to ensure R19 had her physician-ordered Norco available for administration as scheduled for pain management, which resulted in unmanaged pain. This placed R19 at risk of complications related to unmanaged pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. The facility identified a census of 49 residents. The sample included 13 residents with one resident reviewed for dialysis for dialysis (a procedure where impurities or wastes were removed from the blood). Based on observation, record review, and interview, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services regarding Resident (R) 19's health status with each procedure. This deficient practice placed R19 at risk for complications related to dialysis. Findings included: - R19's Electronic Medical Record (EMR) documented diagnosis of hypertension (HTN- elevated blood pressure), end-stage renal disease (ESRD-a terminal disease of the kidneys), and type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R19's Annual Minimum Data Set (MDS) dated 07/05/24 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R19 utilized a wheelchair for mobility and required moderate to maximal assistance from staff for functional abilities. R19 took pain medications for pain management. R19 was on dialysis. R19's Skin Care Area Assessment (CAA) dated 07/07/24 documented she had the potential for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as result of pressure, or pressure in combination with shear and/or friction) development related to immobility, incontinence, and ESRD. R19's Care Plan last revised on 07/07/24 directed staff to ensure R19 goes to dialysis as scheduled on Monday, Wednesday, and Friday. The staff was directed to educate the resident on the importance of dialysis and provide educational material if needed. R19's Orders tab of the EMR documented an order dated 07/19/24 for dialysis three times a week on Monday, Wednesday, and Friday. Chair time is at 06:40 AM. A review of R19's Dialysis Communication Sheets revealed the facility lacked sheets from 03/25/24 to 08/21/24. On 10/15/24 at 08:03 AM R19 sat on her bed in her room. R19 stated she missed her dialysis appointment due to being in quite a bit of pain. R19 stated that the facility would send the communication sheet with her to her dialysis appointment, but she did not always return with the paper. On 10/15/24 at 08:05 AM Licensed Nurse (LN) G stated that the dialysis communication sheet was completed by facility staff prior to R19 being taken to dialysis. LN G stated the communication sheet was sent with R19 on her scheduled day, but the sheet did not always come back with the resident. LN G stated she had not ever called the dialysis clinic to request the communication sheet or the health information when the sheet had not come back with R19. On 10/17/24 at 10:15 AM Administrative Nurse D provided all the dialysis sheets she could find. Administrative Nurse D stated the facility had not had a medical records person for a while so the dialysis sheets that had not been scanned yet could be waiting to be scanned in. Administrative Nurse D (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the nurse should be obtaining vital signs and completing the communication sheets prior to R19 going for her scheduled appointments. Administrative Nurse D stated that staff nurses should be calling the dialysis clinic to have them fax the sheet to the facility. The End-Stage Renal Disease, Care of a Resident policy documented the following. Agreements between this facility and the contracted ESRD facility included all aspects of how the resident's care would be managed including how the care plan would be developed and implemented; and how information would be exchanged between the facilities. The resident's comprehensive care plan would reflect the resident's needs related to ESRD and dialysis care. The facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services regarding R19's health status with each procedure. This deficient practice placed R19 at risk for complications related to dialysis.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. The facility had a census of 49 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week. This placed all residents who reside at the facility at risk of decreased quality of care. Findings included: - The Payroll-Based Journal [PBJ-a required detail of staffing information submitted by nursing homes) provided by the Centers for Medicare and Medicaid Services (CMS) documented the facility lacked RN eight-hour coverage for the following months: July 2023- five days August 2023- six days September 2023- two days October 2023- five days November 2023- two days December 2023- five days January 2024- seven days February 2024- four days April 2024- seventeen days May 2024- four days On 10/15/24 at 10:00 AM, Administrative Staff A reviewed the dates provided and verified the facility lacked RN eight-hour coverage for those dates. Upon request a policy for staffing was not provided by the facility. The facility failed to provide RN coverage eight consecutive hours a day, seven days a week. This placed all residents who reside at the facility at risk of decreased quality of care.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 49 residents. The sample included 13 residents, with six reviewed for behaviors. Based on observation, record review, and interview, the facility failed to immediately involve the physician and provide supportive mental health services to attain Resident (R) 30's highest practicable mental and psychosocial well-being after he made statements of self-harm. This placed the resident at risk for unmet mental health care needs and related complications. Findings included: - The Electronic Medical Record (EMR) for R30 documented diagnoses of stomach cancer, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), heart failure, hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The admission Minimum Data Set (MDS), dated [DATE], documented R30 had intact cognition. He required set-up assistance with toileting and upper body dressing. R30 was independent with personal hygiene, mobility, transfers, and ambulation. The MDS noted R30 had no behaviors and received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and an antianxiety (a class of medications that calm and relax people) medication. R30's Care Plan, dated 08/14/24, directed staff to administer medications as ordered, document signs and symptoms of depression, negative mood, and comments, and report to the nurse. The care plan directed staff to observe and document suicidal ideation, agitation, and attention-seeking behaviors. The care plan lacked documentation of interventions to address R30's self-harm statements. The Physician's Order, dated 08/30/24, directed staff to administer Effexor XR (an antidepressant), 75 milligrams (mg), by mouth, in the morning, for depression. The Physician's Order, dated 10/15/24, directed staff to administer lorazepam (antianxiety medication), two mg/milliliters(ml), or 0.25 ml every two hours, as needed, for anxiety or shortness of breath. The Nurse's Note, dated 10/05/24 at 09:09 PM, documented R30 voiced to himself and staff that he wanted to leave and kill himself. R30 stated he was depressed and that he had nothing to live for anymore and just wanted to die. Staff observed R30 go outside and lay on some rocks. Staff were able to talk to R30 and assist him back into the facility; hospice was notified. R30 stated he was in pain and staff administered his oxycodone and as needed lorazepam. R30 was provided his call light and staff would monitor. The EMR lacked documentation that R30's physician was notified and lacked documentation of staff monitoring after he made self-harm statements. On 10/14/24 at 02:41 PM, observation revealed R30 sat in his wheelchair in his room with his head lying on the bed. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 08:28 AM, Certified Nurse Aide (CNA) M stated that R30 was on hospice. CNA M stated R30 always said he would like to go home but had not heard that the resident wanted to harm himself. On 10/17/24 at 10:05 AM, Licensed Nurse (LN) H stated R30 did tell staff he wanted to harm himself but since then he has been pretty upbeat and has come out of his room to smoke. On 10/17/24 at 11:45 AM, Administrative Nurse D stated R30 did state he wanted to harm himself and hospice staff did come talk with him. Administrative Staff D stated a form was usually filled out to document when staff are monitoring. Administrative Nurse D stated she was unable to see that anything was filled out and said she did not see that the physician had been notified of the self-harm statements. The facility's Suicide Threats policy, dated 12/07, documented, that residents' suicide threats shall be taken seriously and addressed appropriately. Staff shall report any dent threats of suicide immediately to the nurse supervisor or charge nurse. The nurse shall immediately assess the situation and shall notify the charge nurse supervisor and Director of Nursing Services of that threat. The nurse supervisor would assess the resident notify the physician and responsible party and seek further direction from the physician. If the resident stayed in the facility, the staff would monitor the resident's mood, and behavior and update the care plan accordingly until a physician has determined that a risk of suicide does not appear to be present. Staff shall document details of the situation objectively in the resident's medical record. The facility failed to immediately involve the physician and provide supportive services to attain the highest practicable mental and psychosocial well-being for R30, who made statements of self-harm. This placed the resident at risk for unmet mental health care needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility identified a census of 49 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure accurate reconciliation of controlled medications (substances that have an accepted medical use, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) was completed. This placed residents at risk of medication misappropriation and diversion. Findings included: - A review of the Tanglewood Narcotics Shift Count Sheet from 08/01/24 to 10/15/24 revealed 44 missed opportunities for staff signature verifying completion of the narcotic reconciliation by the on-coming and off-going nurse. On 10/15/24 at 08:03 AM Licensed Nurse (LN) G stated the narcotics shift count sheet should be signed by the on-coming and the off-going nurse at each shift after the count has been completed. On 10/17/24 at 08:15 AM Administrative Nurse D stated she expected the nurses at the end of their shift and the on-coming nurse to each sign the narcotic sign-off sheet after the count of the narcotics and exchanging of the medication cart keys each shift. Administrative Nurse D stated she would re-educate the nurses to ensure this was completed each shift. The Controlled Substances policy documented Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises. The Director of Nursing Services will identify staff members who are authorized to handle controlled substances. Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record. If the count is correct, an individual resident-controlled substance record must be made for each resident who will be receiving a controlled substance. Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. The charge nurse on duty would maintain the keys to controlled substance containers. The Director of Nursing Services (DON) would maintain a set of backup keys for all medication storage areas including keys to controlled substance containers. Unless otherwise instructed by the DON, when a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampules (or it is not given), the medication shall be destroyed (witnessed by 2 Licensed Nurses) and may not be returned to the container. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON. The facility failed to ensure accurate reconciliation of controlled medications was completed consistently. This placed residents at risk of medication misappropriation and diversion.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 49 residents. The sample included 13 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported that staff failed to follow the physician's orders to administer insulin (medications used to help reduce the amount of sugar present in the blood) to Resident (R) 44. This placed the resident at risk for physical decline and an ineffective medication regimen. Findings included: - The Electronic Medical Record (EMR) for R44 documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary tract infection (UTI-an infection in any part of the urinary system), and lymphedema (swelling caused by accumulation of lymph fluid). The Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition and required substantial assistance from staff for eating, toileting, bathing, mobility, and transfers. The assessment revealed R44 received insulin and a diuretic (a medication to promote the formation and excretion of urine) medications. R44's Care Plan, dated 09/03/25, directed staff to administer diabetes medication as ordered, obtain a dietary consultation for nutritional regimen, and discuss with R44 the importance of compliance with dietary restrictions. The plan directed to observe for hypoglycemia (low blood sugar) and obtain Accu-checks (blood glucose monitoring test) with a sliding scale as ordered. The Physician's Order, dated 08/30/24, directed staff to administer insulin apart (fast-acting insulin), six units (U), subcutaneous (SQ) (beneath the skin), before meals, for DM. The Physician's Order, dated 08/30/23, directed staff to administer insulin glargine (a long-acting insulin), 25 U, SQ, at bedtime, for DM. The September 2024 Medication Administration Record (MAR) lacked documentation R44 received the insulin aspart on the following days: 09/10/24 at 08:00 PM 09/11/24 at 08:00 PM 09/20/24 at 08:00 PM The September 2024 MAR lacked documentation R44 received the insulin glargine on the following days: 09/10/24 at 04:30 PM 09/12/24 at 04:30 PM (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R44's Medication Regimen Review for the month of October 2024 lacked evidence the CP identified and reported R44 had not been administered the insulin as ordered. On 10/4/24 at 01:20 PM, observation revealed R44 lay in bed with her eyes closed. On 10/17/24 at 12:45 PM, Administrative Nurse D stated she had not been informed by the CP that R44 had not received her physician-ordered insulin. The facility's Pharmacy Services - Role of the Consultant Pharmacist policy, dated 04/07, documented the facility hall obtain and retain the services of a Consultant Pharmacist, who shall provide evidence of current licensure and appropriate training to provide those services. The Consultant Pharmacist would help identify and evaluate medication-related issues, identify pertinent resources and references about medications and their proper use and monitoring in the population, and help the nursing staff evaluate and optimize their medication administration and documentation processes. The Consultant Pharmacist would provide appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record. The facility failed to ensure the CP identified and reported that staff failed to follow the physician's orders to administer insulin to R44. This placed the resident at risk for physical decline and an ineffective medication regimen.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 49 residents. The sample included 13 residents with six sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 19's as-needed antihypertensive (a class of medication used to treat high blood pressure) medication hydralazine was given per physician-ordered parameters. The facility failed to ensure R44's insulin (a hormone that lowers the level of glucose in the blood) was administered as directed. This placed these residents at risk of medication-related complications and possible adverse reactions. Findings included: - R19's Electronic Medical Record (EMR) documented diagnosis of hypertension (HTN- elevated blood pressure), end-stage renal disease (ESRD-a terminal disease of the kidneys), and type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R19's Annual Minimum Data Set (MDS) dated 07/05/24 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R19 utilized a wheelchair for mobility and required moderate to maximal assistance from staff for functional abilities. R19 took pain medications for pain management. R19 was on dialysis (a procedure where impurities or wastes are removed from the blood). R19's Skin Care Area Assessment (CAA) dated 07/07/24 documented she had the potential for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as result of pressure, or pressure in combination with shear and/or friction) development related to immobility, incontinence, and ESRD. R19's Care Plan last revised on 07/07/24 directed staff to administer medications as directed. R19's Orders tab of the EMR documented an order dated 02/26/24 for hydralazine 25 milligrams (mg) tablet to be given every six hours as needed for elevated blood pressure. This order was discontinued on 07/17/24. R19's Orders tab of the EMR documented an order dated 07/21/24 for hydralazine 25mg tablet to be given as needed (PRN) for HTN for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than 160 millimeters of mercury (mmHg) This order was discontinued on 09/05/24. A review of R19's July 2024 Medication Administration Record (MAR) lacked evidence she received her physician-ordered PRN hydralazine on four opportunities for a SBP greater than 160 mm/Hg. A review of R9's August 2024 MAR lacked evidence she received her physician-ordered PRN hydralazine on 43 of 124 opportunities for a SBP greater than 160 mm/Hg. On 10/15/24 at 10:15 AM R19 sat on her bed talking with her son. R19 stated sometimes she did not get her medications as she should. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 07:45 AM Licensed Nurse (LN) H stated all medications should be given per the physician's orders. LN H could not say for certain why R19 had not been given her PRN hydralazine as ordered but said R19 should have received the medication if her SBP was over 160 mmHg. On 10/17/24 at 07:57 AM Administrative Nurse D stated that all medications should be given as per the order. Administrative Nurse D stated she could not state a reason why R19's hydralazine had not been given as it should have been. Administrative Nurse D stated the physician had been trying to get R19's blood pressure lower and had prescribed some new medications to get her blood pressure lowered. The facility policy Administering Oral Medication documented: Verify that there is a physician's medication order for this procedure. Perform any pre-administration assessments. The facility failed to ensure staff administered R19's PRN hydralazine as the physician ordered when her SBP reading was greater than 160 mmHg. This placed R19 at risk of complications and adverse reactions. - The Electronic Medical Record (EMR) for R44 documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary tract infection (UTI-an infection in any part of the urinary system), and lymphedema (swelling caused by accumulation of lymph fluid). The Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented R44 had intact cognition and required substantial assistance from staff for eating, toileting, bathing, mobility, and transfers. The assessment revealed R44 received insulin and hypoglycemia (a group of medications used to help reduce the amount of sugar present in the blood) and diuretic (a medication to promote the formation and excretion of urine) medications. R44's Care Plan, dated 09/03/25, directed staff to administer diabetes medication as ordered, obtain a dietary consultation for nutritional regimen, and discuss with R44 the importance of compliance with dietary restrictions. The plan directed to observe for hypoglycemia (low blood sugar) and obtain Accu-checks (blood glucose monitoring test) with a sliding scale as ordered. The Physician's Order, dated 08/30/24, directed staff to administer insulin apart (fast-acting insulin), six units (U), subcutaneous (SQ) (beneath the skin), before meals, for DM. The Physician's Order, dated 08/30/23, directed staff to administer insulin glargine (a long-acting insulin), 25 U, SQ, at bedtime, for DM. The September 2024 Medication Administration Record (MAR) lacked documentation R44 received the insulin aspart on the following days: 09/10/24 at 08:00 PM 09/11/24 at 08:00 PM 09/20/24 at 08:00 PM The September 2024 MAR lacked documentation R44 received the insulin glargine on the following days: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/10/24 at 04:30 PM 09/12/24 at 04:30 PM On 10/4/24 at 01:20 PM, observation revealed R44 in bed with her eyes closed. On 10/17/24 at 10:00 AM, Licensed Nurse (LN) H stated that if the MAR had blank spaces in it, it meant the medication was not given. LN H said staff were supposed to write a progress note as to why the medication was not given. On 10/17/24 at 12:45 PM, Administrative Nurse D stated that if the insulin was not given, there should be a progress note for the reason the insulin was not administered. The facility's Administering Medications policy, dated 12/12, documented that medications should be administered in a safe and timely manner, and as prescribed. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next one. The facility failed to administer insulin as ordered to R44. This placed the resident at risk for physical decline.

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility identified a census of 49 residents. The facility had one main kitchen and one main dining area. Based on observation, record review, and interview the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed residents at risk for unmet dietary and nutritional needs. Findings included: - On 10/14/24 at 08:16 AM Dietary BB stated she had not taken her test to get her dietary manager certification, but she had begun her courses to get the certification. Dietary BB stated that Administrative Staff A did have a CDM certification. Dietary BB stated that the registered dietician came to the facility twice a month to review the resident's diets. On 10/15/24 at 12:27 PM Administrative Staff A stated she had a CDM certification but did not actively use it. Administrative Staff stated Dietary BB had been taking the courses to get certified and was overseen by the dietician who came to the facility twice monthly. The Food Services Manager policy documented: The daily functions of the Food Services Department are under the supervision of a qualified Food Services Manager. The Food Services Manager is a qualified supervisor licensed by this state and is knowledgeable and trained in food procurement storage, handling, preparation, and delivery. The Food Services Manager was responsible for the daily functions of the Food Services Department in accordance with the facility ' s department policies and procedures. Additional responsibilities of the Food Services Manager included supervision, training, and scheduling of kitchen supervisors; and assisting the dietitian and the nursing services department. The facility failed to ensure the director of food and nutrition services had the required qualifications of a CDM. This placed residents at risk for unmet dietary and nutritional needs.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility had a census of 49 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to hold food at a safe temperature for Resident (R) 36's room tray. This placed the resident at risk for foodborne illness. Findings included: - R36's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial heart) flutter, muscle weakness, and need for assistance with personal care. The Quarterly Minimum Data Set, dated 10/03/24, documented R36 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by gross impairment in reality perception), or exhibited behaviors. R36 had no functional range of motion impairment, used a wheelchair, required setup or clean-up assistance with eating, and weighed 258 pounds. The MDS further documented that R36 received insulin (a hormone that lowers the level of glucose in the blood) and opioids (medication used to treat pain). R36's Care Plan dated 10/14/24, documented that R36 had potential for weight loss related to edentulous (without natural teeth). The plan directed staff to assess for and provide food preferences, provide and serve diet as ordered, and report to the nurse when 50 percent (%) of meals are not eaten. The Physician Order, dated 06/25/24, directed staff to serve a regular diet, regular texture, and regular consistency. The Nutritional Assessment dated 07/02/24, documented R36 had a regular diet order, no known food allergies, required set-up assistance for meals, and was able to self-select menu. On 10/14/24 at 12:50 PM, R36 was observed sitting in his room, in a motorized wheelchair, with a meal tray on an overbed table. He was feeding himself. He stated the food was cold when the room tray was delivered. R36 reported he did order off the alternative menu, but did not get the alternative selection. On 10/15/24 at 08:30 AM, upon request, Dietary Staff BB measured the temperatures of the food on the room tray just removed from the insulated cart The food was on a plate with an insulated cover. Dietary Staff BB's temperature reading for the fried eggs was 97.7 degrees Fahrenheit (F) and the cream of wheat temperature reading was 139 F. Dietary Staff BB reported the temperatures should have been above 145 F. Dietary Staff BB allowed Certified Nurse Aide (CNA) M to take the meal tray to R36's room. Upon inquiry regarding the safety of consuming foods at below-holding temperatures, Dietary Staff BB instructed CNA M to remove the tray from the resident's room and said a new plate would be fixed for R36. CNA M went to R36's room, and R36 became very agitated and yelled at staff not to take his meal. Staff attempted to educate the resident, but he declined and told staff to leave his room, using foul language and throwing his hands in the air. The staff left the room tray with the resident and exited the room. On 10/17/24 at 09:04 AM, Licensed Nurse (LN) H reported R36 had complained about cold food, but (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought it had improved over the past 30 days. On 10/17/24 at 11:30 AM, Administrative Nurse D verified the residents should be served food at safe temperatures. The facility's Food Preparation and Service, dated 12/2008, documented that food service employees shall prepare and serve food in a manner that complies with safe food handling practices. The danger one for food temperatures is between 41 degrees and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. The facility failed to maintain safe food temperatures for R36's room tray. This placed the resident at risk of foodborne illness.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 49 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 37 received thickened liquids per his orders. This placed R37 at risk of complications of aspiration (inhaling liquid or food into the lungs). Findings included: - R37 Electronic Medical Record (EMR) documented diagnosis of hypertension (HTN-elevated blood pressure), alcohol abuse, tobacco use, delirium (sudden severe confusion, disorientation, and restlessness) due to known physiological conditions, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), cerebral aneurysm (weakening area in an artery), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and abnormalities of gait and mobility. The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R37 had severe cognitive impairment, delusions, and rejected care behaviors which occurred one to three days of the look-back period and wandered four to six days of the look-back period. R37 required setup or clean-up assistance with eating and oral hygiene. The MDS further documented that R37 had a swallowing disorder of holding food in the mouth or cheek or residual food in the mouth after meals, coughed or choking during meals or when taking medications, and was on a mechanically altered diet. R37's Care Plan, dated 07/17/24, documented R37's potential for a fluid deficit related to diet. The care plan directed staff to ensure R37 had access to type and consistency fluids (nectar thickened) whenever possible and ensure all beverages complied with diet and fluid restrictions and consistency requirements. The Referral/Screen to Rehab. Services dated 03/07/24, documented R37 had changes in self-feeding and /or swallowing status of coughing, choking, or complaining of pain or discomfort during meals or when swallowing. The staff requested an order from the physician for speech therapy. The Referral/Screen to Rehab. Services dated 03/20/24, documented a recent change in activities of daily living (ADL), gait status, and recent falls. R37 required increased assistance with transfers, bed mobility, wheelchair mobility, gait, dressing, and grooming hygiene. There was a new onset of weakness due to illness/hospitalization. The staff requested an order from the physician for all therapy services. Upon request, the facility failed to provide speech therapy evaluation or treatment. The facility provided physical therapy treatment notes. The Physician Order, dated 03/26/24, documented R37's diet order included nectar consistency liquids. The Physician Order dated 07/17/24 documented there should not be a water pitcher at R37's bedside. The Progress Note dated 03/26/24, documented that staff noticed R37 to be coughing during meals (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drinking fluids, and having a runny nose. R37's diet was downgraded to mechanical soft with nectar-thickened liquids and speech to evaluate. The Physician Progress Note dated 08/19/24, documented R37 was not interested in physical or occupational therapy for his post-stroke symptoms. On 10/17/24 at 07:40 AM observation revealed R37 sat in the dining room. Activity Staff Z provided R37 with a glass of thin-liquid cranberry juice, which R37 promptly drank. Activity Staff Z initially stated R37 did not have thickened liquid, but then returned to report he had been mistaken and verified he gave R37 regular liquid though R37 should have received thickened liquids. On 10/17/24 at 08:28 AM, Administrative Nurse D verified R37's diet order for thickened liquids. Upon request, the facility did not provide a policy related to thickened liquids. The facility failed to provide R37 with nectar-thick liquids per his orders. This placed the resident at risk of complications related to aspiration of liquids.

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Tanglewood Nursing & Rehabilitation	5015 SW 28th Street Topeka, KS 66614

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 49 residents. The facility had one main kitchen. Based on observation and interview, the facility failed to ensure staff stored food items in accordance with the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination (the transfer of harmful substances to food). Findings included: - Upon the initial tour of the main kitchen on 10/14/24 at 08:16 AM observation in the refrigerator revealed a block of cheese wrapped in plastic wrap that lacked a label or a date. There was a sealed bag of ham slices with no label or date. There were several brown-tinged towels on the floor under the stove. In the dry storage room, there were opened bags of potato chips, tortilla chips, and gravy mix that were not in a sealed and labeled bag. Dietary Staff BB stated on 10/14/24 at 08:25 AM that the food items all should be placed in a sealed bag and then labeled and dated. Dietary BB stated she had been working hard on training staff to ensure that any time a food was opened it must be placed in a sealed bag and labeled and dated. The Food Receiving and Storage policy revised in December 2008 documented that dry foods that are stored in bins will be removed from their original packaging, labeled, and dated (use by date). Such foods will be rotated using a first in - first out system. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). Refrigerated foods will be stored in such a way that promotes adequate air circulation around food storage containers. Refrigerators/walk-ins will not be overcrowded. The facility failed to ensure dietary staff stored food items in accordance with the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 49 residents. Based on interviews and record review, the facility failed to submit complete and accurate staffing information through Payroll-Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024 Quarter (Q) 2 indicated no licensed nurse coverage on eight days. The PBJ for FY 2024 Q2 recorded no licensed nurse coverage on the following dates: 02/11/24, 02/17/24, 02/24/24, 03/09/24, 03/16/24, 03/24/24, 03/30/24 and 03/31/24. Review of the facility licensed nurse payroll data for the dates listed above revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 10/15/24 at 10:00 AM, Administrative Staff A stated the information for the PBJ was submitted from someone off campus and the error was probably due to agency staff not accounted for. Administrative Staff A stated there was always a licensed nurse in the building and that there were more registered nurses than there used to be. Upon request a policy for Payroll-Based Journal was not provided by the facility. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility had a census of 49 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to implement Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R) 45's indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), R7's gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) care, and R43's wound care. The facility failed to ensure R33's eye medication was administered using adequate infection control standards and failed to ensure R7's oxygen equipment was changed and stored in a sanitary manner. This placed the residents at risk for infectious processes. Findings included: - On 10/14/24 at 02:44 PM, observation revealed R43's door to her room had a personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) caddy hanging on it that only had face masks in it; there were no gowns in her room. On 10/15/24 at 07:45 AM, observation revealed that R30's oxygen tubing and cannula were wrapped around an oxygen tank, unbagged. On 10/15/24 at 08:30 AM, observation revealed R43's PPE caddy on her door had masks and gloves but no gowns. On 10/15/24 at 09:16 AM, Certified Nurse Aide (CNA) O pushed R43 into the bathroom, donned clean gloves but not a gown, assisted R43 to stand up, and pulled down R43's pants. CNA O pulled off part of the dressing that was on R43's right buttock wound. The wound bed was yellow, with redness to the skin surrounding the wound and there was no drainage apparent. On 10/15/24 at 01:30 PM, R7 lay on his bed. Licensed Nurse (LN) G knocked on his door and announced herself and stated she was going to be giving him his Glucerna. LN G donned gloves but no gown and flushed R7's G-tube with 150 ml of water prior to pouring the Glucerna into the syringe attached to the G-tube. LN G then poured the bolus of Glucerna into the syringe until all was emptied through the tube. LN G then poured an additional 30 cc of water into the tube to flush. LN G said she was unsure if R7 required EBP. On 10/15/24 at 02:04 PM, observation revealed CNA N emptying R45's catheter. R45's room lacked signage for EBP. CNA N explained to R45 that she was going to empty the catheter bag. CNA N placed gloves on and retrieved the measuring cylinder from the bathroom, gathered an incontinent wipe from a package on the overbed table, unhooked the drainage bag from the underside of the resident's wheelchair, drained the collection bag, wiped the drainage spicket with an incontinent wipe, then laid the drainage bag directly on the floor, smoothed it out flat, then placed the drainage back to the underside of the wheelchair. CNA N did not wear a gown during the procedure. On 10/17/24 at 08:00 AM, observation revealed R30's oxygen tubing and cannula were wrapped around the back of the oxygen concentrator unbagged. On 10/17/24 at 09:07 AM, observation revealed Certified Medication Aide (CMA) S administering eye drops to R33. CMA S verified the medication order with the electronic record, retrieved the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication from the medication cart, entered R33's room, and announced she would administer the resident's eye drop. CMA S did not place gloves on her hands, instructed R33 to look upwards and CMA S rested her hand on the forehead of R33 while administering a drop of medication into R33's right eye. CMA S stated it was her usual practice not to use gloves when administering eye drops for R33. On 10/17/24 at 08:25 AM, CNA M stated she thought R43 had something on her door that had gowns, gloves, and masks to wear when staff assisted R43 but did not know why. She stated R30 wore his oxygen off and on and stated when he did not have it on, the tubing should be stored in a bag. On 10/15/24 at 08:52 AM, Administrative Nurse D said that when not in use, oxygen tubing and cannula are to be stored in a bag. On 10/17/24 at 09:04 AM Licensed Nurse (LN) H stated CNA N should not have placed the catheter bag directly on the floor. LN H also verified that R45 should be on EBP related to the indwelling catheter and should wear a gown and gloves during catheter care. LN H verified that R45 did not have signage or a supply of PPE available in the room or near the room. On 10/17/24 at 09:56 AM, LN H stated R43 was on EBP due to her pressure ulcer and staff wear gowns and gloves when staff provide care. On 10/17/24 at 11:00 AM, Administrative Nurse D stated staff should wear gloves when administering eye drops. On 1/17/24 at 12:15 PM, Administrative Nurse D stated that R43's door caddy should have had the necessary PPE for staff to use when providing care and that the care plan should have her EBP status on it. On 10/17/24 at 03:00 PM, Administrative Nurse D reported catheter bags should not be laid directly on the ground and that staff should implement EBP during care for residents with catheters. The facility's Enhanced Barrier Precautions policy, dated 04/01/24, documented that Enhanced Barrier Precautions are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi-drug resistant organism (MDRO)'s to staff hands and clothing. EBP is indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Facilities should ensure PPE and alcohol-based hand rubs are readily accessible to staff. The facility's Oxygen Use policy, dated 03/04, documented, for safe oxygen administration, verified that there was a physician's order for oxygen use, and reviewed the care plan for any special needs of the resident. Check the tubing connected to the oxygen cylinder to ensure that it is free of kinks and turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. The facility's Instillation of Eye Drops policy, dated 01/2014, directed staff to put on gloves, administer the eye drops, remove gloves, and discard them into a designated container. The facility failed to ensure staff followed EBP for three residents, and failed to use standard infection control practices during eye drop administration and for sanitary storage of respiratory (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tubing. This placed the resident sat risk for increased infections.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep all essential equipment working safely. The facility identified a census of 49 residents. The facility identified one main kitchen. Based on observation, record review, and interview, the facility failed to ensure the kitchen ' s stand-up freezer and plate warmer were in safe operating condition. Findings included: - The initial tour of the kitchen on 10/14/24 at 08:16 AM revealed a stand-up freezer that was not in working condition. The plate warmer located by the stove was unplugged and no plates were present in it. On 10/14/24 at 08:25 AM Dietary BB stated the stand-up freezer had not worked since 09/04/24 and had not been replaced yet. Dietary BB stated she had plugged in the plate warmer last week and it sparked and smelled of smoke, so she unplugged it and notified maintenance and Administrative Staff A immediately. Dietary BB stated a new one had been ordered and should arrive late this week or early next week. On 10/15/24 at 12:28 PM Administrative Staff A stated she was aware that the freezer was not working and would make sure it was removed by the end of the week. Administrative Staff A stated a new plate warmer had been ordered and should arrive by the end of the week or early next week. The facility was unable to provide a policy regarding proper kitchen equipment maintenance. The facility failed to ensure the kitchen ' s stand-up freezer and plate warmer were in safe operating condition.