STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175501	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family Health & Rehabilitation Center	639 S Maize Court Wichita, KS 67209

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. The facility identified a census of 64 residents. The sample included 16 residents with one resident reviewed for abuse and neglect. Based on observation, record review, and interviews, the facility failed to ensure staff reported an allegation of staff-to-resident abuse for Resident (R) 25 to the facility administrator immediately. The facility additionally failed to report R25's allegation of abuse to the State Agency (SA) as required. This placed R25 at risk for unidentified and ongoing abuse and /or neglect. Findings included: - The Medical Diagnosis section within R25's Electronic Medical Records (EMR) included diagnoses of acute kidney failure, lower extremity deep vein thrombosis (potentially life-threatening blood clot, usually in the legs), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (progressive mental disorder characterized by failing memory, and confusion). R25's admission Minimum Data Set (MDS) completed 01/25/24 noted a Brief Interview for Mental Status score of 13 indicating mild cognitive impairment. The MDS indicated she required touch assistance for bathing, toileting, dressing, bed mobility, personal hygiene, and transfers. The MDS noted she had a history of falls. The MDS noted no behaviors or care refusals. R25's Functional Abilities Care Area Assessment (CAA) completed 01/25/24 indicated she required staff assistance to complete her activities of daily living (ADLs). The MDS indicated she had venous wounds to her left lower heel. R25's Pressure Ulcer CAA completed 01/25/24 indicated she had a venous ulcer (wound caused by poor blood circulation) to her lower left extremity. The CAA instructed staff to implement pressure-reducing devices and frequent repositioning. R25's Care Plan initiated 02/11/24 indicated she required supervision for bed mobility, dressing, transfers, meals, bathing, personal hygiene, and toileting. The plan noted she was at risk for pain related to her neuropathy and lower left extremity wound. The plan instructed staff to inspect her for skin breakdown, complete skin checks, and encourage adequate nutrition. The plan instructed staff to respect her wishes, concerns, and preferences. The plan encouraged her to verbalize her fears and concerns. The plan encouraged her to discuss her depression and anxiety. The plan lacked evidence showing a history of accusations and behaviors. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's EMR under Progress Notes revealed a note entered on 03/19/24 at 02:36 AM. The note indicated R25 reported to nursing staff at 09:00 PM (03/18/24) that the Certified Nurse's Aide (CNA) taking care of her hurt her leg and was rough with her. The note indicated R25 was sobbing and crying. The progress note lacked evidence the situation was reported to the administrator, physician, and family. A Resident/Family Concern form completed 03/19/24 at 07:20 AM indicated R25 reported to Administrative Nurse E that during her shower the previous evening (03/18/24) R25 requested her plastic wound covering be rolled hallway down and cut off after her shower was completed. R25 reported instead of cutting it off staff pulled her wound cover plastic off her leg causing severe pain and burning sensations to her wounded leg. The grievance was signed by Administrative Nurse E and Administrative Staff A. On 04/24/24 at 11:15 AM R25 sat in her room on her bed. R25 stated she could not remember the specific incident but remembered staff pulling off her leg dressing and that she was left in pain. She stated staff pulled the cover off her wound. She stated she reported it to the facility. She stated she currently felt safe in the facility. On 04/23/24 at 03:45 PM Administrative Nurse D stated she was made aware of the issue, but the facility did not report the issue as an alleged abuse because she reviewed the cameras, and she did not feel the incident was abuse. She stated the incident was not reported to the SA. She stated staff were expected to report all alleged allegations of abuse to the administrator immediately and notify the SA. She reported the facility had annual abuse, neglect, and exploitation in-service training. On 04/24/24 at 10:23 AM Administrative Nurse E stated she was called to R25's room by staff to talk to R25 on 03/19/24 at 07:11 AM. She stated R25 was crying and reported she was hurt by the overnight staff during her shower. She stated R25 told her that the staff member pulled her protective plastic shower cover off her leg instead of cutting it off. She stated R25 preferred staff to cut the plastic cover off to prevent pain in her lower extremity wound. Administrative Nurse E stated she immediately reported the incident to Administrative Staff A and Administrative Nurse D at 07:15 AM. On 04/24/24 at 10:12 AM Administrative Staff A stated she was not notified of the allegation until Administrative Nurse E brought the grievance to her on 03/19/24. She stated the allegation was not reported to the SA because R25 had a history of making complaints towards staff and the facility reviewed the situation and felt it was not abuse. She identified the alleged perpetrator as Certified Nurses Aid (CNA)TT. She stated she was not notified by the night shift staff of the alleged abuse allegation. The facility's Reporting of Abuse Neglect, and Exploitation (ANE) policy revised 01/13/23 indicated all alleged or suspected mistreatment, neglect, or abuse will be immediately reported to the facility's administrator. The policy indicated the facility will also report. The facility failed to ensure staff immediately notified the administrator of an allegation of abuse and additionally failed to report the allegation of abuse to the SA. This placed R25 at risk for unidentified and ongoing abuse and /or neglect.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. The facility identified a census of 64 residents. The sample included 16 residents with one resident reviewed for abuse and neglect. Based on observation, record review, and interviews, the facility failed to protect Resident (R)25 and other vulnerable residents during the facility investigation after an abuse allegation. This placed R25 and the other residents under the care of Certified Nurse Aide (CNA) TT at risk for unidentified and ongoing abuse and /or neglect. Findings included: - The Medical Diagnosis section within R25's Electronic Medical Records (EMR) included diagnoses of acute kidney failure, lower extremity deep vein thrombosis (potentially life-threatening blood clot, usually in the legs), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (progressive mental disorder characterized by failing memory, and confusion). R25's admission Minimum Data Set (MDS) completed 01/25/24 noted a Brief Interview for Mental Status score of 13 indicating mild cognitive impairment. The MDS indicated she required touch assistance for bathing, toileting, dressing, bed mobility, personal hygiene, and transfers. The MDS noted she had a history of falls. The MDS noted no behaviors or care refusals. R25's Functional Abilities Care Area Assessment (CAA) completed 01/25/24 indicated she required staff assistance to complete her activities of daily living (ADLs). The MDS indicated she had venous wounds to her left lower heel. R25's Pressure Ulcer CAA completed 01/25/24 indicated she had a venous ulcer (wound caused by poor blood circulation) to her lower left extremity. The CAA instructed staff to implement pressure-reducing devices and frequent repositioning. R25's Care Plan initiated 02/11/24 indicated she required supervision for bed mobility, dressing, transfers, meals, bathing, personal hygiene, and toileting. The plan noted she was at risk for pain related to her neuropathy and lower left extremity wound. The plan instructed staff to inspect her for skin breakdown, complete skin checks, and encourage adequate nutrition. The plan instructed staff to respect her wishes, concerns, and preferences. The plan encouraged her to verbalize her fears and concerns. The plan encouraged her to discuss her depression and anxiety. The plan lacked evidence showing a history of accusations and behaviors. R25's EMR under Progress Notes completed by Licensed Nurse (LN) L revealed a note entered on 03/19/24 at 02:36 AM. The note indicated R25 reported to nursing staff at 09:00 PM (03/18/24) that the CNA taking care of her hurt her leg and was rough with her. The note indicated R25 was sobbing and crying. The progress note lacked evidence the situation was reported to the administrator, physician, and family. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Resident/Family Concern form completed 03/19/24 at 07:20 AM indicated R25 reported to Administrative Nurse E that during her shower the previous evening (03/18/24) R25 requested her plastic wound covering be rolled hallway down and cut off after her shower was completed. R25 reported instead of cutting it off staff pulled her wound cover plastic off her leg causing severe pain and burning sensations to her wounded leg. The grievance was signed by Administrative Nurse E and Administrative Staff A. The note indicated LN L was placed on the Do Not Return (DNR) list for the facility after the incident occurred. A review of the facility's investigation completed on 03/19/24 indicated no protective measures, corrective actions, or additional training occurred after the abuse allegation was made known to the facility. A review of Certified Nurse's Aides (CNA) TT's timecard for 03/18/24 indicated she clocked in at 04:47 PM and clocked out at 09:41 PM. CNA TT's records indicated she returned to work on 04/20/24. On 04/24/24 at 11:15 AM R25 sat in her room on her bed. R25 stated she could not remember the specific incident but remembered staff pulling off her leg dressing and that she was left in pain. She stated staff pulled the cover off her wound. She stated she reported it to the facility. She stated she currently felt safe in the facility. On 04/23/24 at 03:45 PM Administrative Nurse D stated she was made aware of the issue, but the facility did not report the issue as an alleged abuse because she reviewed the cameras, and she did not feel the incident was abuse. She stated staff were expected to report abuse, separate the alleged perpetrator, and assess the resident's health/safety. On 04/24/24 at 10:23 AM Administrative Nurse E stated she was called to R25's room by staff to talk to R25 on 03/19/24 at 07:11 AM. She stated R25 was crying and reported she was hurt by the overnight staff during her shower. She stated R25 told her that the staff member pulled her protective plastic shower cover off her leg instead of cutting it off. She stated R25 preferred staff to cut the plastic cover off to prevent pain in her lower extremity wound. Administrative Nurse E stated she immediately reported the incident to Administrative Staff A and Administrative Nurse D at 07:15 AM. On 04/24/24 at 10:12 AM Administrative Staff A stated she was not notified of the allegation until Administrative Nurse E brought the grievance to her on 03/19/24. She identified the alleged perpetrator as Certified Nurses Aid (CNA)TT. She stated she was not notified by the night shift staff of the alleged abuse allegation. She stated LN L was placed on Do Not Return (DNR) status at the facility due to conflicts on the unit. She stated his DNR was not related to the abuse allegation. The facility's Reporting of Abuse Neglect, and Exploitation (ANE) policy revised 01/13/23 indicated all alleged abuse allegations will be immediately investigated by the facility. The policy indicated the resident would immediately be assessed and separated from the alleged perpetrator until a thorough investigation had been completed. The policy indicated the administrator will be immediately notified of all abuse allegations. The facility failed to protect R25 after an alleged abuse allegation. This placed R25 and the other residents under the care of CNA TT at risk for unidentified and ongoing abuse and /or neglect.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The sample included 16 residents. One resident was sampled for accidents and hazards. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 42's fall interventions as directed by her care plan. This deficient practice placed R42 at risk of falls and related injuries. Findings included: - R42's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), epilepsy (brain disorder characterized by repeated seizures), a feeding tube (tube for introducing high-calorie fluids into the stomach), and transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain). The Quarterly Minimum Data Set (MDS) dated [DATE] documented that the facility was unable to conduct a Brief Interview of Mental Status (BIMS) score, R42's MDS documented the resident was rarely or never understood. The MDS documented R42 was dependent on staff for all activities of daily living (ADLs). R42's Falls Care Area Assessment (CAA) dated 06/05/23 documented R42 was at risk for falls related to poor safety awareness and a history of falls. R42 used a wheelchair for mobility. She required staff assistance with transfers and mobility. She had a history of falls with interventions in place. R42 was at risk of falls related to her impaired physical mobility. R42's Care Plan dated 02/03/23 documented that staff would arrange R42's bed next to the wall, and her bed would be in the lowest position. R42's Care Plan dated 03/21/23 documented staff would place a fall mat next to the bed for R42's safety. On 04/22/24 at 07:38 AM R42 laid in bed on her right side, with her eyes shut. R42's floor mat was rolled up next to her small dresser and the bathroom door. R42's bed was pulled away from the wall. On 04/23/24 at 07:36 AM R42 lay in bed on her back, her feet were pulled up next to her chest at times and moving randomly in the air. R42's fall mat was not in place next to her bed and her bed was pulled away from the wall. On 04/24/24 at 08:08 AM Licensed Nurse (LN) I stated every nursing staff member was responsible for the care of each resident. LN I stated all staff members can find the fall precautions for each resident in the care plan. LN I stated each time care plans were updated; it was discussed in the morning during the facility's huddle and report. LN I stated R42's fall mat should have been in place on the floor next to her bed while she was in her bed. On 04/24/24 at 09:00 AM Certified Nursing Aide (CNA)P stated all nursing staff were responsible for the safety of each resident. CNA P said nurses were responsible for ensuring all fall precautions were in place and stated the CNAs got updates for each resident in the report before their shift. CNA P said she was unaware R42's bed should be against the wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 12:43 PM Administrative Nurse D stated if R42 was in bed, the fall mats should have been in place and the bed should be against the wall. Administrative Nurse D stated all facility nurses knew where the care plans, were. She stated nursing staff knew where the fall preventions were in the care plan. The facility's Falls policy revised on 01/18/24 documented each patient residing at eh facility is provided services and care that ensures that the patients' environment remains as free from accident hazards as possible and that injuries are minimized. The facility failed to ensure R42's bed was next to the wall, and that her fall mats were in place while R42 was in her bed. This deficient practice placed R42 at risk of falls.

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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. The facility identified a census of 64 residents. The sample included 16 residents with three reviewed for urinary catheters (a tube inserted into the bladder to drain urine) care. Based on observations, record reviews, and interviews, the facility failed to follow standards of practices related to indwelling catheter care for Resident (R)44. This deficient practice placed R44 at risk for catheter-related complications including urinary tract infections (UTI). Findings included: - The Medical Diagnosis section within R44's Electronic Medical Records (EMR) included diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (weakness and paralysis on one side of the body), aphasia (a condition with disordered or absent language function), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and 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). R44's Annual Minimum Data Set (MDS) completed 01/18/24 noted a Brief Interview for Mental Status score of zero indicating severe cognitive impairment. The MDS indicated he required maximal assistance with transfers, bed mobility, bathing, personal hygiene, dressing, and mobility. The MDS indicated he had an indwelling urinary catheter. The MDS indicated he was at risk for developing pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). The MDS indicated he had pressure-reducing devices for his wheelchair and bed in place. The MDS indicated he weighed 164 pounds (lbs.) upon admission. R44's Pressure Ulcer Care Area Assessment (CAA) completed 01/25/24 indicated he returned from an acute care facility with a stage two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer to his coccyx (area at the base of the spine). The CAA indicated a care plan would address his pressure ulcer risks. R44's Urinary Catheter Care Area Assessment (CAA) completed 01/25/24 indicated he had neurogenic bladder dysfunction and required an indwelling urinary catheter. The CAA indicated a care plan would address catheter care needs. The MDS indicated he was dependent on staff for all his activities of daily living (ADLs). R44's Care Plan initiated on 04/06/23 indicated he was at risk for falls, skin breakdown, and an ADL deficit related to his medical diagnoses. The plan indicated he was dependent on staff to complete transfers, toileting, bed mobility, bathing, dressing, and personal hygiene. The plan instructed staff to provide urinary catheter care each shift. The plan instructed staff to check the tubing for kinks and ensure the catheter collection bag remained below the level of his bladder. On 04/22/24 at 09:07 AM R44 slept in his bed. His bed was in the lowest position with a fall mat positioned on the floor to the left side. R44's urinary catheter bag lay on the floor at the foot of his bed on the right side. At 11:10 AM R44's catheter bag remained on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/24 at 09:02 AM Licensed Nurse (LN) K completed hand hygiene and gathered supplies for catheter care for R44. LN K donned gloves and a gown and placed the catheter care supplies on the resident's bedside table. LN K adjusted the table knocking over two small bottles from the table onto the floor. LN K picked up the items with her gloved hands and placed them back on the table. Wearing the same gloves, LN K removed R44's covers and unfastened his incontinence brief. LN K inspected R44's groin area and refastened his brief. LN K unfastened R44's catheter stat-lock (device to stabilize the catheter tubing) and prepped the catheter port to be flushed. LN K wiped the catheter port with a sanitary wipe. LN K filled a syringe with 60 milliliters (ml) of saline solution. LN K grabbed R44's catheter port and flushed 60ml of saline solution. R44 became agitated and requested the task be stopped. LN K then removed her gloves but failed to complete hand hygiene before donning clean gloves. LN K wiped R44's catheter port and reattached the stat-lock. LN K repositioned R44 and gathered the supplies used. LN K stated staff were expected to check R44's catheter collection bag placement during each encounter to ensure it was not on the floor. On 04/24/24 at 09:30 AM R44 rested in his bed. His urinary catheter collection bag lay on the floor of the right side of his bed. Yellow urine pooled in the tubing as the bag sat on the floor. On 04/24/24 at 08:30 AM Certified Nurses Aid (CNA) UU stated R44's urine collection bag should be attached to the bed and never be on the floor due to contamination risks. On 04/24/24 at 12:43 PM Administrative Nurse D stated R44's urinary collection bag should be placed below the level of his bladder. She stated staff should be completing hand hygiene in between glove changes and when touching soiled surfaces or items. The facility did not provide a policy related to urinary catheter care as requested on 04/24/24. The facility failed to follow standards of practices related to indwelling catheter care for R44. This deficient practice placed R44 at risk for complications related to UTI.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The sample included 16 residents with one resident reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to monitor Resident (R) 39's access site for complications at least daily and failed to obtain communication from the dialysis center related to R39's treatment. These deficient practices placed R39 at risk of potential adverse outcomes and physical complications related to dialysis. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), end-stage renal disease (ESRD-a terminal disease of the kidneys), and dependence on dialysis. The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R39 received dialysis during the observation period. R39's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 03/22/24 documented she required staff assistance with her toileting needs. R39's Care Plan dated 07/07/24 documented the facility would communicate R39's condition with the dialysis provider per a written communication form with each of R39's dialysis visits. The plan of care documented the nursing staff would monitor R39's arteriovenous (AV-a surgically created connection between an artery and a vein) fistula located in her left upper chest, every shift, before and upon return from dialysis for dislodgement, signs, or symptoms of infection such as redness, edema, or drainage. R39's EMR under the Orders tab revealed the following physician orders: Prepare dialysis paperwork every Monday, Wednesday, and Friday dated 06/13/23. Complete dialysis assessment day shift every Monday, Wednesday, and Friday dated 12/17/23. R39's clinical record revealed staff assessed the AV site after R39 returned from dialysis on Monday, Wednesday, and Friday but lacked evidence staff assessed the site on non-dialysis days and as needed. A review of R39's clinical record and information provided by the facility lacked evidence of communication between the facility and the dialysis provider on the following dialysis dates: 01/10/24, 01/19/24, 01/29/24, 01/31/24, 02/09/24, 02/26/24, 03/06/24, 03/15/24, 03/22/24, 03/27/24, 04/01/24, 04/08/24, and 04/22/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 09:20 AM R39 sat in her wheelchair at the dining room table and ate her breakfast without assistance. R39 sat and visited with several other residents. On 04/24/24 at 09:20 AM, Certified Nurse Aide (CNA) RR stated she assisted R39 with getting her dialysis bag together for R39's scheduled dialysis appointments. On 04/24/24 at 09:40 AM, Licensed Nurse (LN) G stated the nurse would fill out a communication form for R39 to take to the dialysis center and if the communication sheet did not return from the dialysis center when R39 returned, the nurse would call the provider. LN G stated the nurse would document that report from the dialysis center in R39's EMR under the progress note tab. LN G stated R39's AV fistula should be assessed, and the nurse would document the assessment under the assessment tab in R39's EMR. Ln g confirmed R39's EMR under the assessment tab lacked consistent documented assessment of R39's AV fistula. On 04/24/24 at 12:44 PM, Administrative Nurse D stated she expected R39's AV fistula to be assessed for bleeding and/or infection every shift and documented in her EMR. The facility's Hemo-Dialysis Policy dated 12/03/23 documented it was the policy of this facility to provide excellence in care and services to residents with End Stage-Renal Disease (ESRD) receiving heme-dialysis at a certified renal dialysis unit off-site. Facility staff would initiate a written communication form that would accompany the resident off-site to the Dialysis Unit and returned, completed by the Dialysis Unit staff for every visit. Facility staff would inspect and document the fistula site every day for a pulse-if a pulse is not palpated or cannot be auscultated with a stethoscope, notify the Dialysis Unit immediately. Facility staff would assess and document signs of infection daily. The facility failed to monitor R39's dialysis access site at least daily for signs of infection, bleeding, and the status of the dressing in place and failed to obtain communication from the dialysis center. These deficient practices placed R39 at risk of potential adverse outcomes and physical complications related to dialysis.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family Health & Rehabilitation Center	639 S Maize Court Wichita, KS 67209

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The facility had four medication carts. Based on observation, record review, and interview, the facility failed to ensure accurate reconciliation of controlled substances (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 consistently. This placed residents at risk of medication misappropriation and diversion. Findings included: - On 04/22/24 at 09:18 AM, an observation of the medication cart on [NAME] House revealed the narcotic reconciliation sign-off sheets from 03/07/24 to 03/31/24 lacked a signature on 11 of 152 opportunities. On 04/22/24 at 09:18 AM, an observation of the medication cart on [NAME] House revealed the narcotic reconciliation sign-off sheets from 04/01/24 to 04/21/24 lacked a signature on 16 of 136 opportunities. On 04/22/24 at 11:26 AM Certified Medication Aide (CMA) S stated that the narcotic sign-on and off sheet should be signed after the narcotic count has been completed and the keys to the medication cart have been exchanged between the off-going and the oncoming staff member. On 04/22/24 at 02:11 PM, Licensed Nurse (LN) G stated she expected staff to be signing on and off on the narcotic count sheet at the beginning and end of each shift after the narcotic count was completed and the medication cart keys had been exchanged between the off-going nurse or CMA and the oncoming staff. On 04/22/24 at 02:24 PM Administrative Nurse D stated the narcotic sign-on and off sheets were expected to be signed by the off-going and the on-coming nursing staff at the end and beginning of each shift exchange of the keys for the medication cart. The facility did not provide a policy for controlled medication reconciliation. The facility failed to ensure an accurate reconciliation of controlled substances was consistently completed. This placed residents at risk of medication misappropriation and diversion.

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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. The facility reported a census of 64 residents. The sample included 16 residents with five reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to follow the physician-ordered parameters related to Resident (R)17's as-needed (PRN) bumetanide (diuretic-medication to promote the formation and excretion of urine). This deficient practice placed R17 at increased risk for unnecessary medication and side effects. Findings included: - The Medical Diagnosis section within R17's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), left femur (large leg bone) fracture (bone break), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues). R17's Quarterly Minimum Data Set (MDS) completed 04/05/24 noted a Brief Interview for Mental Status score of 11 indicating mild cognitive impairment. The MDS indicated she required touch assistance for transfers, bed mobility, dressing, bathing, personal hygiene, and ambulation. The MDS indicated she took diuretic medication. R17's Urinary Incontinence Care Area Assessment (CAA) completed 01/15/24 indicated she was incontinent of the bladder. The CAA indicated she required partial assistance to the restroom. The CAA indicated she took diuretic medications to assist with her edema. R17's Care Plan initiated 04/09/24 indicated she took medications with Black Box Warnings (BBW- highest safety-related warning that medications can be assigned by the Food and Drug Administration). The plan indicated she took bumetanide and instructed staff to monitor for weight gain or loss. R17's EMR indicated she was to be weighed every Wednesday and Sunday morning. R17's EMR under Physician's Order revealed an order (dated 01/02/24) instructing staff to administer two milligrams of bumetanide by mouth twice daily for edema. The order instructed staff to monitor R17's weight and administer an additional two milligrams PRN for weight gains over (>) three pounds (lbs.). R17's Medication Administration Report (MAR) indicated the PRN medication had not been administered since ordered. R17's EMR under Weight History indicated she had weight gains of over three pounds on 01/14/24 (3.5 lbs.), 01/21/24 (7.0 lbs.), 03/20/24 (4.0 lbs.), 04/07/24 (4.0 lbs.) and 04/14/24 (3.5 lbs.). On 04/22/24 at 08:03 AM R17 sat in her recliner. Her feet were propped out in the recliner. She reported no pain or current swelling in the lower extremities. R17 reported she completed most of her ADLs with minimal assistance needed. R17 walked to the dining room using her support walker. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 10:21 AM Licensed Nurse (LN) G stated nurses would follow the parameters given for diuretic medications and notify the physician if changes occurred for the medications or weights. She stated R17 had concerns with her lower extremity edema but was walking better now. On 04/24/24 at 12:43 PM Administrative Nurse D state staff were expected to follow the ordered parameters of the physicians. She stated the PRN medication should have been given for R17 if her weight increased over three pounds. The facility's Medication Administration policy revised 01/2024 indicated staff will ensure adequate monitoring and medication with black box warnings and significant risks. The policy indicated staff will follow the physician's intended indication and instructions for medication administrations. The facility failed to follow the physician-ordered parameters related to R17's PRN diuretic medication. This deficient practice placed R17 at increased risk for unnecessary medication and side effects.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. The facility identified a census of 64 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure the medication error rate did not exceed five percent (%) when staff failed to ensure Resident (R) 12 was administered her scheduled morning medications within the ordered timeframe. The facility failed to ensure the insulin (a hormone that lowers the level of glucose in the blood) pen and needle were appropriately primed before insulin administration to R161. This resulted in a medication error rate of 46.15%. Findings included: - On 04/22/24 at 12:20 PM Certified Medication Aide (CMA) WW washed her hands and returned to her medication cart to begin dispensing medications for R12. CMA WW pulled up R12's Medication Administration Record (MAR) and pulled R12's medication cards from the medication cart. CMA WW dispensed each medication (listed below) into a medication cup. CMA WW walked with the medication cup over to R12 who sat at the dining table eating lunch. R12 placed several of her medications in her hand at a time and placed them in her mouth and swallowed them without difficulty. R12 continued to place her medications into her mouth until all the pills had been taken. CMA WW returned to her medication cart and laptop to sign off on the medication that R12 had taken. On 04/22/24 at 12:42 PM, Licensed Nurse (LN) J was administering R161 his scheduled lispro insulin. LN J washed her hands and unlocked her cart to gather R161's insulin pen, disposable needle, and an alcohol wipe. LN J verified the amount to administer by looking at R161's MAR. LN J walked over to R161's room after locking her medication cart and the screen on her laptop. LN J donned clean gloves. LN J then knocked on R161's door, she announced herself and told R161 what she was there for. LN J entered R161's room and walked over to where he was seated. LN J took the lid off the insulin pen she held in her hand and opened an alcohol wipe to wipe the hub of the pen for several seconds with the alcohol wipe. LN J then opened the disposable insulin needle and screwed it onto the end of the insulin pen. LN J dialed the insulin pen to 15 units. LN J opened another alcohol wipe as she lifted the sleeve of R161's shirt and wiped his right upper arm with the alcohol wipe and then inserted the insulin needle into R161's arm and administered the insulin. LN J failed to prime the pen and needle with two units of insulin before the administration of the 15 scheduled units. A review of R12's physician's orders revealed a scheduled administration time of 08:00 AM for her omeprazole (a medication used to treat acid reflux) 40 milligrams (mg), probiotic (a supplement taken to improve the good bacteria in the digestive system), ferosul (iron supplement), Thera-m (a multivitamin supplement), acetaminophen (pain reliever, fever reducer), and aspirin. Review of R12's physician's orders revealed a scheduled administration time of 06:00 AM to 10:00 AM for the following medications: nebivolol (a medication used to treat high blood pressure), potassium chloride (a medication used for treatment of low potassium), lisinopril-hydrochlorothiazide (a combination medication used to lower blood pressure and a medication used to rid the body of extra salt and water), and fluticasone propionate nasal suspension (a medication used to treat season and year-round allergies). R12 was administered the above physician-ordered medications outside of the allowable timeframe for medication administration which included up to one hour before and one hour after the scheduled administration time of 08:00 AM and 06:00 AM to 10:00 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/22/24 at 01:00 PM, CMA WW stated she was the only CMA passing medications to two houses and she had gotten behind today. CMA WW stated R12's medications should be administered no more than one hour before or one hour after the scheduled time. On 04/22/24 at 12:45 PM, LN J stated she was not aware that the insulin needle needed to be primed before the administration of the insulin. LN J could not say what the policy for insulin administration said. On 04/22/24 LN G stated it was common standard of practice to prime the insulin pen and needle with two units before the scheduled amount. LN G stated she would be re-educating her nursing staff regarding this. LN G stated all medication was expected to be administered within a one-hour window before or after the scheduled time. LN G stated there should not be any reason for R12's medications to be administered late. LN G stated on the long-term care side the nurse and the CMA both should be administering the medication and expected to get all medications given on time. On 04/22/24 at 02:24 PM Administration Nurse D stated she expected staff to prime the insulin pen/needle with two units before administration. Administrative Nurse D stated that was just standard practice and expected her nursing staff to be aware of that. Administrative Nurse D stated she expected nursing staff administering medications to make sure the medications were given within the one-hour window before or after the scheduled time. Administrative Nurse D stated R12 had many medications had a scheduled time between 06:00 AM and 10 AM and should be no reason for the medications to be late. The facility policy Medication Administration last revised 01/16/24 documented: that this facility implements a liberalized medication administration policy for timing of medication administration. In the event the medication was ordered more than daily, the time of administration would be written on the MAR, accompanied by the initials verifying administration and time of administration of the medications. The facility failed to ensure the medication error rate did not exceed five percent when staff failed to ensure R 12 was administered her scheduled morning medications within the allowable timeframe. The facility failed to ensure the insulin pen and needle were appropriately primed before insulin administration to R161. This resulted in a medication error rate of 46.15%.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The facility had four medication storage refrigerators and four medication carts. Based on observation, record review, and interview, the facility failed to ensure safe and secure storage of medications and biologicals. This deficient practice created a risk of adverse side effects and ineffective medication administration. Findings included: - On 04/22/24 at 07:32 AM the medication refrigerator on the [NAME] House was left unlocked, and there was insulin (a hormone that lowers the level of glucose in the blood) for several residents unsecured. On 04/22/24 at 07:36 AM the medication refrigerator on [NAME] House was left unlocked and insulin for residents was unsecured. The inside of the refrigerator had a large amount of ice formation at the top. On 04/22/24 at 07:38 AM a medication cart on [NAME] House was left unlocked, and there was no nursing staff around the cart to monitor. The Nursing Facility Surveyor (NFS) stayed at the cart until Licensed Nurse (LN) H came and locked the cart. On 04/22/24 at 07:40 AM LN H stated all carts should be locked unless the staff was in site of the cart. LN H stated when a refrigerator was opened for medication it should be immediately locked after each medication pass. On 04/22/24 at 02:24 PM Administrative Nurse D stated she expected nursing staff to keep the medication carts and the medication refrigerators locked when not used. Administrative Nurse D stated nursing staff should lock the medication cart every time they stepped away from the cart or were out of direct sight of the cart. The facility policy Medication Storage last revised 02/14/24 did not address the storage of medications in the medication carts or medication refrigerators. The facility failed to ensure safe and secure storage of medications and biologicals which created a risk for adverse medication effects and ineffective medication administration.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The facility identified 25 residents on enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care). Based on observations, record review, and interviews, the facility failed to ensure consistent infection control standards were followed related to enhanced barrier precautions, storage of oxygen tubing, indwelling catheter (tube placed in the bladder to drain urine into a collection bag) care, laundry, and shared equipment. These deficient practices placed the residents at risk for complications related to infectious diseases. Findings Included- - On 04/22/24 at 08:00 AM an inspection of the identified EBP rooms revealed Resident (R)45 and R8's rooms lacked the required signage identifying the precautions needed to provide care. All 25 of the reviewed enhanced barrier precaution rooms stored the personal protective equipment (PPE) inside the rooms. An inspection of the facility's [NAME] House laundry room revealed soiled pillows, clothing, and a foot brace lying directly on the floor. On 04/22/23 at 08:19 AM an inspection of R210's room revealed her supplemental oxygen tubing and nasal cannula (tubing that delivers oxygen directly through both nostrils of the nose) draped over the back of the stationary oxygen machine. An inspection of her portable oxygen cylinder revealed the tubing draped over the oxygen cylinder. No clean storage bags or containers were available in her room to store the oxygen tubing. The tubing remained outside of a sanitary storage device until staff provided bags on the morning of 04/23/24. On 04/22/24 at 09:07 AM R44 slept in his bed. His bed was in the lowest position with a fall mat positioned on the floor to the left side. R44's urinary catheter bag lay on the floor at the foot of his bed on the right side. At 11:10 AM R44's catheter bag remained on the floor. On 04/23/24 at 08:38 AM Certified Nurse Aide (CNA) M pushed the Hoyer (total body mechanical lift) out of R45's room back into the hallway after use and returned to R45's room without disinfecting the lift after use. On 04/23/24 at 08:32 AM Licensed Nurse (LN) K prepared R42's enteral feeding (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) supplies. R42 was on EBP due to her percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach). LN K failed to wear the required gown while administering R42's enteral feeding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/23/24 at 09:02 AM Licensed Nurse (LN) K completed hand hygiene and gathered supplies for catheter care for R44. LN K donned gloves and a gown and placed the catheter care supplies on the resident's bedside table. LN K adjusted the table knocking over two small bottles from the table onto the floor. LN G picked up the items with her gloved hands and placed them back on the table. Wearing the same gloves, LN K removed R44's covers and unfastened his incontinence brief. LN K inspected R44's groin area and refastened his brief. LN K unfastened R44's catheter stat-lock (device to stabilize the catheter tubing) and prepped the catheter port to be flushed. LN K wiped the catheter port with a sanitary wipe. LN K filled a syringe with 60 milliliters (ml) of saline solution. LN K grabbed R44's catheter port and flushed 60ml of saline solution. R44 became agitated and requested the task be stopped. LN K then removed her gloves but failed to complete hand hygiene before donning clean gloves. LN K wiped R44's catheter port and reattached the stat-lock. LN K repositioned R44 and gathered the supplies used. LN K stated staff were expected to check R44's catheter collection bag placement during each encounter to ensure it was not on the floor. On 04/24/24 at 09:30 AM R44 rested in his bed. His urinary catheter collection bag lay on the floor of the right side of his bed. Yellow urine pooled in the tubing as the bag sat on the floor. Certified Nurses Aid (CNA) UU stated R44's urine collection bag should be attached to the bed and never be on the floor due to contamination risks. She reattached R44's catheter collection bag to his bed. On 04/23/24 at 09:30 AM LN K stated hand hygiene should be completed in between PPE use or when visibly soiled. She stated the urinary collection bag should be secured to the bed and never allowed to touch the floor. On 04/24/24 at 07:30 AM, CNA UU stated the unit's staff were responsible for completing the resident's laundry and maintaining the items in the laundry room. She stated items should never be left on the floor. She stated catheter bags should be stored on the bed or below the level of the bladder and oxygen equipment should be stored in a bag when not in use. She stated hand hygiene should be completed before, during, and after care with the residents. On 04/24/24 at 12:43 PM Administrative Nurse D stated staff were expected to complete hand hygiene and glove changes whenever visibly soiled or in between glove changes. She stated that shared equipment and lifts were disinfected weekly. She stated oxygen tubing and equipment were to be stored in a clean bag when not in use. She stated signage should be posted inside the enhanced barrier precautions rooms along with the personal protective equipment. She was not able to explain what enhanced barrier precautions were or used for. She stated the facility stored the equipment inside the rooms due to the high number of residents on enhanced barrier precautions in the facility. The facility's Infection Control policy revised 07/2023 indicated the facility will ensure the safe handling of medications, medical equipment, laundry, and environment to prevent the transmission of communicable diseases and avoid preventable infections. The policy indicated staff will follow designated standards and contact precautions per federal standards and Centers for Disease Control (CDC) guidelines. The facility's Enhanced Barrier Precautions revised 01/2024 indicated precautions will be implemented for residents with known colonized or targeted drug-resistant organisms for a resident with open wounds, urinary catheters, PEG tubes, and increased risks for infections related to open skin sites. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure consistent infection control standards were followed related to EBP, oxygen equipment, indwelling catheter care, laundry, and shared equipment. These deficient practices placed the residents at risk for complications related to infectious diseases.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility had a census of 64 residents. The sample included 16 residents and three Certified Nurse Aides (CNAs) reviewed for 12 hours of required in-service training. Based on record review and interview, the facility failed to ensure three of the three CNA staff reviewed had the required 12 hours of in-service education which included the required dementia management training. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA N, hired on 01/19/23 lacked evidence of dementia in-service training. CNA O, hired on 06/16/20 lacked evidence of dementia in-service training. CNA P, hired on 02/21/22 lacked evidence of dementia in-service training. A review of the Elopement and Missing Resident in-service training provided by the facility included one slide titled Characteristics of dementia and progressive dementia but lacked direction for staff on interventions and methods of approach for residents with dementia. A review of the Communication in-service training provided by the facility included a slide titled Ten Tips for Improving Communication with a Resident with Dementia, but dementia lacked direction on providing care to residents with dementia and how to identify and implement interventions to promote quality of life for residents with dementia. On 04/24/24 at 08:25 AM, Administrative Staff A stated that required in-services were completed electronically. Administrative Staff A stated the dementia training was in the facility's elopement training and communication in-services. On 04/24/24 at 12:44 PM, Administrative Nurse D stated the facility's dementia training was provided electronically at the time of hire and annually. Administrative Nurse D stated she did provide some in-services to the facility staff monthly. Administrative Nurse D stated she was unsure if dementia was a required training topic. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Required Training and In-Services of Staff policy dated 12/08/23 documented the facility developed, implemented, and maintains an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with defined and expected roles. The facility determines the amount and types of training necessary based on the Facility Assessment and individual training needs based on each staff member's performance evaluation. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers will be consistent with expected roles. It is the policy of this facility that all certified personnel including but not limited to Certified Nurse Aides and Certified Medication Aides participate in regularly scheduled in-service training classes based on Federal Rules of Participation and on identified educational needs of each staff member through competency evaluation. The facility failed to ensure three CNA staff reviewed had dementia management training part of the required 12 hours of in-service education. This placed the residents at risk for inadequate care.