STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175509	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Heights	440 State Street Little River, KS 67457

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. The facility reported a census of 22 residents and included 11 residents sampled and reviewed for care plan revision. Based on observations, interviews, and record reviews, the facility failed to ensure the care plans were reviewed and revised to develop and implement appropriate interventions to prevent multiple falls for three residents, Resident (R) 9, R10 and R14. These deficient practices resulted in ongoing increased risk of falls and had the potential to lead to uncommunicated needs that would negatively affect the physical and psychosocial well-being of the residents. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R)14 included diagnoses of altered mental status (state of awareness that was different from the normal awareness of a person) and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). The 10/02/24 Quarterly Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. The assessment documented R14 utilized a walker and/or wheelchair for locomotion and required substantial/maximal assistance for application of footwear, partial/moderate assistance for all other cares except eating, which required setup/cleanup assistance. The assessment documented R14 was occasionally incontinent of bladder and was always continent of bowel. The assessment documented two or more non-injury falls since the previous assessment. The 01/02/25 Significant Change Minimum Data Set (MDS) documented a BIMS score of four, which indicated severely impaired cognition. The assessment documented R14 utilized a walker and/or wheelchair for locomotion and was dependent on staff for bathing, toileting hygiene and application of footwear. R14 required substantial/maximal assistance with lower body dressing, partial/moderate assistance with upper body dressing, supervision with personal and oral hygiene and setup/cleanup assistance with eating. The assessment documented R14 was always incontinent of urine and occasionally incontinent of bowel. The assessment documented a fall in the six-month look-back period that resulted in a fracture, two or more non-injury falls, two or more falls with minor injury, and one fall with major injury since the previous assessment. The assessment further documented major surgery in the 100-day look-back period that included a partial or total hip replacement. R14 received occupational and physical therapy. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/02/25, documented R14 had a significant memory deficit that caused him to forget he was unable to walk unassisted and had chair and bed alarms, which were intermittently used, due to poor memory. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Falls CAA dated 01/02/25, documented R14 was intermittently able to ambulate (walk) with the assistance of one to two staff members. The 01/07/25 Care Plan documented on 09/20/22 R14 was at risk for falls related to memory deficit and history of falls and included the following interventions: On 09/20/22, staff would leave the night light on in R14's room. On 10/25/22, staff would place non-skid strips in front of R14's bed. On 12/26/22, R14 was a fall risk. On 01/05/23, staff would assist R14 to get ready for bed and remind R14 to utilize the call light to alert staff for assistance. On 08/18/23, staff would assist R14 with evening cares and ensure R14 was wearing non-skid socks. On 09/17/23, R14 would utilize the call light. On 12/23/23, staff would provide more assistance with morning cares and with transfers during the day, R14 would be assisted with evening and bedtime cares and staff would ensure R14 wore non-skid shocks or shoes at all times. On 01/02/24, R14 would utilize the call light On 01/18/24, staff repositioned R14's bed so that the height was appropriate sitting height for R14. On 03/02/24, staff would assist R14 to his room and assist with toileting needs after meals. On 03/07/24, staff would ensure a pressure alarm was on and working properly in R14's bed, recliner and wheelchair. Physical and occupational therapy would evaluate and treat if indicated. On 03/16/24, R14 would utilize the call light for assistance. On 11/26/24, staff would ask physical therapy to evaluate and treat R14 due to weakness and increase in the number of falls. The EHR documented on 07/03/24, 07/09/24, 10/01/24, 11/16/24, 11/23/24, and 12/25/24 that R14 was at risk for falls. The Progress Notes dated 07/09/24 at 05:14 PM documented at approximately 04:45 PM the pressure alarm sounded for R14 and R14 was discovered sitting on the edge of the bed. R14 had a wound on his left leg that was bleeding. R14 stated that he got up and walked to the door, tripped over a shoe, fell to the ground, crawled back to the bed and was able to get himself up into the bed in a seated position. Staff notified R14's durable power of attorney (DPOA - legal document that named a person to make healthcare decisions when the resident was no longer able to) who would transport R14 to the Emergency Department (ED) for evaluation and treatment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes dated 07/09/24 at 09:03 PM documented R14 arrived back in the facility from the ED where R14 received sutures (stitches - medical device to hold body tissues together after an injury or surgery) to the laceration (wound on the skin) that measured four centimeters (cm) by five cm. Review of the facility's fall investigation revealed on 07/09/24 at 06:40 PM, R14 fell with minor injury to the left leg. The facility's root cause analysis determined R14 ambulated without his walker. The resident's Care Plan lacked an intervention related to the fall on 07/09/24. The Progress Notes dated 09/02/24 at 11:40 AM documented R14 had a fall without injury. R14 was heard yelling help and was observed kneeling on the floor at the side of the bed. R14 reported that he slid off the bed. The author documented R14 wore slipper socks and the bed alarm was in place but did not sound. R14 was assessed to have no injuries from the fall. Review of the facility's fall investigation revealed on 09/02/24 R14 fell without injury. The facility's root cause analysis determined the pressure alarm was faulty. The fall investigation report documented an immediate intervention to replace the faulty pressure alarm. The resident's Care Plan lacked an intervention related to the fall on 09/02/24. The Progress Notes dated 11/16/24 at 01:25 PM documented R14 had a fall with minor injury to his head. R14's chair alarm sounded and unnamed Certified Nurse Aide (CNA) observed R14 unsuccessfully attempted to self-transfer from his wheelchair to his bed and fell. R14 struck his head on the nightstand and sustained a 1.5 cm laceration to the back of his head. Staff were able to utilize steri-strips (adhesive wound closures) to close the wound. Review of the facility's fall investigation revealed on 11/16/24 R14 had a fall with minor injury. The facility's root cause analysis determined R14 transferred without assistance. The resident's Care Plan lacked an intervention related to the fall on 11/16/24. The Progress Notes dated 12/25/24 at 07:20 AM documented R14's pressure alarm sounded; staff observed R14 on his right side on the floor. R14's right leg appeared shorter than the left leg and appeared rotated outward and R14 complained of pain to the right hip. The physician was called, and EMS (Emergency Medical Services) was called to transfer R14 to the ED for evaluation and treatment. The Progress Notes dated 12/25/24 at 10:14 AM documented the facility was notified by the ED that R14 was admitted to the hospital with the diagnosis of right hip fracture. The Progress Notes dated 12/25/24 at 11:14 AM documented the facility was notified by the ED that R14 was scheduled for surgery the following day. The Progress Notes dated 12/30/24 at 12:00 PM documented R14 returned to the facility after a partial right hip replacement. Review of the facility's fall investigation dated 12/25/24 revealed R14 had a fall with major injury. The facility's root cause analysis determined R14 was ambulating without assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Care Plan lacked an intervention related to the fall on 12/25/24. The Progress Notes dated 01/30/25 at 06:34 PM documented R14 was found with the upper half of his body on the bed with his lower body off the bed with right knee resting on the floor. The facility lacked a fall investigation report for the fall on 01/30/25 with root cause analysis. The resident's Care Plan lacked an intervention related to the fall on 01/30/25. During an observation on 03/12/25 at 02:41 PM, R14 was seated in a wheelchair in the common area with peers present. R14's right leg rested on the foot pedal of the wheelchair in a semi-extended position with knee-immobilizer observed on right leg. Roll-back brakes and pressure alarm observed on R14's wheelchair. During an interview on 03/13/25 at 09:37 AM, CNA J revealed if a resident was on the floor, she would ask the resident why they were on the floor. If the resident stated that they were not on the floor by their choice then it was considered an unwitnessed fall, and the nurse would be notified. During an interview on 03/13/25 at 09:51 AM, Certified Medication Aide (CMA) H revealed a fall is defined as a change in plane (standing to seated, seated/laying to ground). CMA H revealed if a resident fell, staff would notify the nurse and follow the nurse's instructions. During an interview on 03/13/25 at 01:22 PM, Licensed Nurse (LN) G revealed after a fall, the resident was assessed, a fall packet was completed which included root cause analysis and development of an intervention to put in place and a new intervention on the permanent care plan. The nurse would then communicate the change verbally to the staff on shift and communicate to oncoming shifts with the communication book. During an interview on 03/03/25 at 01:32 PM, Administrative Nurse C revealed that a fall is defined an unintentional change in plane. Administrative Nurse C confirmed the lack of care plan interventions for R14's 07/09/24, 09/02/24 and 11/16/24 falls. Administrative Nurse C revealed that the immediate intervention for the 12/25/24 fall was one-on-one observation and support until EMS arrived and confirmed that it was not documented in the fall investigation report. Administrative Nurse C confirmed the progress noted dated 01/30/25 should have initiated a fall investigation since the resident had a change in plane. Administrative Nurse C revealed that after a fall, the nurse completed the fall packet which was then routed to her and she would investigate the fall with the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.). The IDT team met weekly and would determine the appropriateness of interventions and would also to evaluate if additional interventions are required specific to that fall. Administrative Nurse C revealed that she would also consult with Administrative Nurse B about falls more frequently than the weekly IDT meetings. The facility's undated Care Plan Revisions policy documented the care plan would be revised after every fall and would include specific instructions to staff based on identified risk factors at the time of the fall and during the fall investigation process to prevent or reduce the possibility of recurrent falls. The facility failed review and revise the permanent care plan for R14 to mitigate the risk for additional falls after a fall with minor injury on 07/19/24, a fall without injury on 09/02/24, a fall (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with minor injury on 11/16/24, a fall with major injury on 12/25/24 and fall without injury on 01/30/24. This deficient practice placed R14 at risk for uncommunicated needs as well as continued and on-going risk for falls which had the potential to negatively impact R14's physical and psychosocial well-being. - Review of the Electronic Health Record (EHR) for Resident (R) 9 included diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and repeated falls. The 11/20/24 Quarterly MDS documented the BIMS score of 14, which indicated intact cognition. The assessment documented R9 utilized a wheelchair for locomotion and required partial/moderate assistance with bathing, supervision/touching assistance for oral and toileting hygiene, setup/cleanup assistance for all other cares except personal hygiene which was performed independently. The assessment documented two or more non-injury falls since the previous assessment. R9 received dialysis and oxygen. The 02/12/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The assessment documented R9 utilized a wheelchair for locomotion and required partial/moderate assistance with bathing, supervision/touching assistance for oral and toileting hygiene, setup/cleanup assistance for all other cares except personal hygiene which was performed independently. The assessment documented two or more non-injury falls since the previous assessment. R9 received dialysis and oxygen. The Falls Care Area Assessment (CAA) dated 01/12/25, documented most of R9's falls occurred on evenings after dialysis. The 02/18/25 Care Plan, reviewed 03/12/25, documented on 03/09/22 R9 was at risk for falls related to history of falling and included the following interventions: On 03/09/22, when staff passed by R9's room, they would ensure she was in the center of her bed to prevent falls and encourage proper bed alignment. Staff would place non-skid strips on the floor where transfers occur, keep personal and frequently used items and call light in reach at all times. Staff would also encourage R9 to change positions slowly and make sure wheelchair was locked before getting out of bed. Staff would also encourage and assist R9 to remove all extra pillows and stuffed animals off of the bed before getting into the bed. On 03/13/22, staff educated R9 to lock both brakes on her wheelchair before self-transfers. On 08/10/22, staff would place a pillow beside R9 while in bed during the day to remind her where the edge of the bed was. On 10/17/22, staff would keep R9's bed at knee-height and wheel chair locked and next to the bed for safe transfers. On 12/20/22, R9 was high fall risk. On 06/23/23, staff would encourage R9 to have the wheelchair closer to the recliner prior to transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/25/24, staff would place non-skid strips on the floor in front of the recliner to help prevent feet from sliding. On 04/05/24, staff would assist R9 to ensure proper footwear, either shoes or non-skid socks. On 04/10/24, staff would rearrange R9's bathroom to be free of clutter and provide more room for additional independence in the bathroom. Staff would also analyze R9's fall to determine a pattern or trend. On 11/27/24, staff would ensure R9 wore slipper socks when not wearing shoes. On 01/09/25, staff would provide R9 with verbal reminders to not ambulate (walk) or transfer without assistance. On 03/08/25, staff would ensure R9 wore her oxygen at all times. Review of Observations in the EHR documented R9 was at risk for falls on 05/29/24, 06/14/24, 08/20/24, 08/23/24, 11/19/24, 11/28/24, 01/09/25 and 02/11/25. The EHR lacked a fall risk assessment after the non-injury fall on 08/23/24. The Progress Note dated 08/23/24 at 03:38 AM documented R9 had a fall without injury. R9 was found by staff on the floor in front of the recliner and was in a seated position. Review of the facility's fall investigation revealed R9 had a fall without injury on 08/23/24. The facility's root cause analysis determined R9 removed the dycem (a non-slip mat used for stabilization and gripping to prevent slipping) from her recliner. The resident's Care Plan lacked an intervention related to the fall on 08/23/24. The Progress Note dated 08/30/24 at 02:40 AM documented R9 had a fall without injury. R9 was found by staff on the floor in front of the recliner and was in a seated position. Review of the facility's fall investigation revealed R9 had a fall without injury on 08/30/24. The facility's root cause analysis determined R9 was not wearing non-skid socks and did not use her call light for assistance. The resident's Care Plan lacked an intervention related to the fall on 08/30/24. During an interview on 03/13/25 at 09:37 AM, CNA J revealed if a resident was on the floor, she would ask the resident why they were on the floor. If the resident stated that they were not on the floor by their choice then it was considered an unwitnessed fall, and the nurse would be notified. During an interview on 03/13/25 at 09:51 AM, Certified Medication Aide (CMA) H revealed a fall is defined as a change in plane (standing to seated, seated/laying to ground). CMA H revealed if a resident fell, staff would notify the nurse and follow the nurse's instructions. During an interview on 03/13/25 at 01:22 PM, Licensed Nurse (LN) G revealed after a fall, the resident was assessed, a fall packet was completed which included root cause analysis and development of an intervention to put in place and a new intervention on the permanent care plan. The nurse would (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then communicate the change verbally to the staff on shift and communicate to oncoming shifts with the communication book. During an interview on 03/03/25 at 02:15 PM, Administrative Nurse C revealed that a fall is defined an unintentional change in plane. Administrative Nurse C confirmed the lack of care plan interventions for 08/23/24 and 08/30/24 falls. Administrative Nurse C revealed that after a fall, the nurse completed the fall packet which was then routed to her and she would investigate the fall with the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.). The IDT team met weekly and would determine the appropriateness of interventions and would also to evaluate if additional interventions are required specific to that fall. Administrative Nurse C revealed that she would also consult with Administrative Nurse B about falls more frequently than the weekly IDT meetings. The facility's undated Care Plan Revisions policy documented the care plan would be revised after every fall and would include specific instructions to staff based on identified risk factors at the time of the fall and during the fall investigation process to prevent or reduce the possibility of recurrent falls. The facility failed review and revise the permanent care plan for R9 to mitigate the risk for additional falls after a fall without injury on 08/23/24 and 08/30/24. This deficient practice placed R9 at risk for uncommunicated needs as well as continued and on-going risk for falls which had the potential to negatively impact R9's physical and psychosocial well-being. - Review of the Electronic Health Record (EHR) revealed that Resident (R)10 included diagnoses of Paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), auditory hallucinations (sensory experiences of hearing sounds or voices that are not present in the external environment), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), restless legs syndrome (a neurological disorder characterized by an irresistible urge to move the legs, often accompanied by unpleasant sensations such as tingling, crawling, or aching), cognitive communication deficit (communication difficulty arising from impaired cognitive processes like attention, memory, or reasoning, rather than a primary language or speech problem), chronic pain syndrome (a condition characterized by persistent pain that lasts at least three months), unspecified systolic (congestive) heart failure (a condition where the heart's left ventricle doesn't pump blood effectively, leading to symptoms like shortness of breath, fatigue, and swelling), and developmental disorder of speech and language (a neurodevelopmental condition that significantly impacts a child's ability to learn, understand, and use language, affecting their speaking, listening, reading, and writing skills). The 05/27/24 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R10 was dependent on staff assistance for toileting hygiene and bathing and required substantial to maximum assistance for upper clothing dress while being totally dependent for lower body dress and footwear. The 05/27/24 Activity of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA), documented R10 was dependent on staff for cares, and he required staff assistance and full lift for all transfers. The 05/27/24 Falls CAA, documented R10 was a high risk for falls related to being wheelchair bound, was unable to use a transfer board, and required the use of full lift for transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 02/19/25 Quarterly MDS, documented a BIMS score of 12 which indicated moderately impaired cognition, and documented no falls since the previous assessment. The assessment documented R10 could feed self with no swallowing problems. The MDS indicated R10 was dependent on staff assistance for toileting hygiene and bathing and required substantial to maximum assistance for upper clothing dress while being totally dependent for lower body dress and footwear. The Care Plan, documented on 11/02/24 R10 was at risk for falls due to intermittent confusion and required a total lift for transfers. R10 did not have the ability to ambulate independently due to paraplegia and included the following interventions: On 11/02/24, staff would reposition the bed in the room. On 11/02/24, Occupational Therapy (OT) (helps people of all ages improve their ability to perform daily activities and participate in meaningful occupations by addressing physical, cognitive, and social challenges) to evaluate R10 for use of a trapeze (provides a person a means of self-help to change position in bed, to move onto a bedpan, to move from a bed to a commode, or to transfer to and from a wheelchair with minimal help from an attendant). The Progress Notes dated 11/02/24 at 11:08 AM, documented R10 was found on his floor and indicated R10 had a fall. The Progress Notes dated 03/07/25 at 10:55 PM, documented R10 slid down his wheelchair while being transferred from the wheelchair to the bed but made no impact on any surfaces. During an interview on 03/11/25 at 03:10 PM, R10 reported he slipped out of the front of his wheelchair recently while transferring and landed on the floor. During an interview on 03/13/25 at 09:37 AM, Certified Nurse Aide (CNA) J stated if resident was sitting on the floor she would first ask (if BIMS allows) why they were on the floor, and if not by choice she would then notify the nurse for assessment. CNA J said if the resident was not on the floor by choice it was considered an unwitnessed fall. CNA J said if she was assisting a resident from the wheelchair to the bed or toilet and they slipped, but did not land on the floor CNA J indicated that was not a fall. CNA J said she would still notify the nurse and help fill out an incident report. During an interview on 03/13/25 at 09:51 AM, Certified Medication Aide (CMA) H reported that a fall is a break in plane. CMA H stated that if a resident slides out of chair, but they're caught before hitting the floor and assisted back into the chair then it's the nurse discretion, the nurse would be notified, and they'd do what they do. CMA H indicated that she usually just tells the nurse. During an interview on 03/13/25 at 09:56 AM, Licensed Nurse (LN) G reported a fall was a difference in the center of gravity. LN G stated that if she caught a resident sliding out of a chair and assists them back into the chair, she would make a progress note about it, but said it was not considered a fall. During an interview on 03/13/25 at 10:59 AM, Administrative Nurse B stated a fall was any unplanned change in plane. Administrative Nurse B reported if staff caught a resident sliding out of their chair and assisted them back into the chair, it was not a fall, it was a prevented fall, and a fall packet was not done but it would be charted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrative Nurse B said for actual falls the nurse performed a full assessment, a fall packet was filled out and the Director of Nursing, Administrator, the resident's Durable Power of Attorney, and the Physician are notified. The facility's undated Care Plan Revisions policy documented the care plan would be revised after every fall and would include specific instructions to staff based on identified risk factors at the time of the fall and during the fall investigation process to prevent or reduce the possibility of recurrent falls. The facility failed to review and revise the permanent care plan for R10 to mitigate the risk for additional falls after a fall on 03/07/25, with a known history of falls. This deficient practice placed R10 at risk for uncommunicated needs as well as continued and on-going risk for falls which had the potential to negatively impact R10's physical and psychosocial well-being.

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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 facility reported a census of 22 residents, with 11 residents sampled, including six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions were implemented to prevent falls for three residents. Resident (R)14 had multiple falls with no fall prevention interventions placed and fell on [DATE] at approximately 07:20 AM, which resulted in a fractured (broken bone) right hip that required hospitalization and surgical repair. The facility also failed to investigate, develop, and implement fall prevention interventions to prevent multiple falls for R9 and R10. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R)14 included diagnoses of altered mental status (state of awareness that was different from the normal awareness of a person) and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). The 10/02/24 Quarterly Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. The assessment documented R14 utilized a walker and/or wheelchair for locomotion and required substantial/maximal assistance for application of footwear, partial/moderate assistance for all other cares except eating, which required setup/cleanup assistance. The assessment documented R14 was occasionally incontinent of bladder and was always continent of bowel. The assessment documented two or more non-injury falls since the previous assessment. The 01/02/25 Significant Change Minimum Data Set (MDS) documented a BIMS score of four, which indicated severely impaired cognition. The assessment documented R14 utilized a walker and/or wheelchair for locomotion and was dependent on staff for bathing, toileting hygiene and application of footwear. R14 required substantial/maximal assistance with lower body dressing, partial/moderate assistance with upper body dressing, supervision with personal and oral hygiene and setup/cleanup assistance with eating. The assessment documented R14 was always incontinent of urine and occasionally incontinent of bowel. The assessment documented a fall in the six-month look-back period that resulted in a fracture, two or more non-injury falls, two or more falls with minor injury, and one fall with major injury since the previous assessment. The assessment further documented major surgery in the 100-day look-back period that included a partial or total hip replacement. R14 received occupational and physical therapy. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/02/25, documented R14 had a significant memory deficit that caused him to forget he was unable to walk unassisted and had chair and bed alarms, which were intermittently used, due to poor memory. The Falls CAA dated 01/02/25, documented R14 was intermittently able to ambulate (walk) with the assistance of one to two staff members. The 01/07/25 Care Plan documented on 09/20/22 R14 was at risk for falls related to memory deficit and history of falls and included the following interventions: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/20/22, staff would leave the night light on in R14's room. On 10/25/22, staff would place non-skid strips in front of R14's bed. On 12/26/22, R14 was a fall risk. On 01/05/23, staff would assist R14 to get ready for bed and remind R14 to utilize the call light to alert staff for assistance. On 08/18/23, staff would assist R14 with evening cares and ensure R14 was wearing non-skid socks. On 09/17/23, R14 would utilize the call light. On 12/23/23, staff would provide more assistance with morning cares and with transfers during the day, R14 would be assisted with evening and bedtime cares and staff would ensure R14 wore non-skid shocks or shoes at all times. On 01/02/24, R14 would utilize the call light On 01/18/24, staff repositioned R14's bed so that the height was appropriate sitting height for R14. On 03/02/24, staff would assist R14 to his room and assist with toileting needs after meals. On 03/07/24, staff would ensure a pressure alarm was on and working properly in R14's bed, recliner and wheelchair. Physical and occupational therapy would evaluate and treat if indicated. On 03/16/24, R14 would utilize the call light for assistance. On 11/26/24, staff would ask physical therapy to evaluate and treat R14 due to weakness and increase in the number of falls. The EHR documented on 07/03/24, 07/09/24, 10/01/24, 11/16/24, 11/23/24, and 12/25/24 that R14 was at risk for falls. The Progress Notes dated 07/09/24 at 05:14 PM documented at approximately 04:45 PM the pressure alarm sounded for R14 and R14 was discovered sitting on the edge of the bed. R14 had a wound on his left leg that was bleeding. R14 stated that he got up and walked to the door, tripped over a shoe, fell to the ground, crawled back to the bed and was able to get himself up into the bed in a seated position. Staff notified R14's durable power of attorney (DPOA - legal document that named a person to make healthcare decisions when the resident was no longer able to) who would transport R14 to the Emergency Department (ED) for evaluation and treatment. The Progress Notes dated 07/09/24 at 09:03 PM documented R14 arrived back in the facility from the ED where R14 received sutures (stitches - medical device to hold body tissues together after an injury or surgery) to the laceration (wound on the skin) that measured four centimeters (cm) by five cm. Review of the facility's fall investigation revealed on 07/09/24 at 06:40 PM, R14 fell with minor injury to the left leg. The facility's root cause analysis determined R14 ambulated without his (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	walker. The resident's Care Plan lacked an intervention related to the fall on 07/09/24. The Progress Notes dated 09/02/24 at 11:40 AM documented R14 had a fall without injury. R14 was heard yelling help and was observed kneeling on the floor at the side of the bed. R14 reported that he slid off the bed. The author documented R14 wore slipper socks and the bed alarm was in place but did not sound. R14 was assessed to have no injuries from the fall. Review of the facility's fall investigation revealed on 09/02/24 R14 fell without injury. The facility's root cause analysis determined the pressure alarm was faulty. The fall investigation report documented an immediate intervention to replace the faulty pressure alarm. The resident's Care Plan lacked an intervention related to the fall on 09/02/24. The Progress Notes dated 11/16/24 at 01:25 PM documented R14 had a fall with minor injury to his head. R14's chair alarm sounded and unnamed Certified Nurse Aide (CNA) observed R14 unsuccessfully attempted to self-transfer from his wheelchair to his bed and fell. R14 struck his head on the nightstand and sustained a 1.5 cm laceration to the back of his head. Staff were able to utilize steri-strips (adhesive wound closures) to close the wound. Review of the facility's fall investigation revealed on 11/16/24 R14 had a fall with minor injury. The facility's root cause analysis determined R14 transferred without assistance. The resident's Care Plan lacked an intervention related to the fall on 11/16/24. The Progress Notes dated 12/25/24 at 07:20 AM documented R14's pressure alarm sounded; staff observed R14 on his right side on the floor. R14's right leg appeared shorter than the left leg and appeared rotated outward and R14 complained of pain to the right hip. The physician was called, and EMS (Emergency Medical Services) was called to transfer R14 to the ED for evaluation and treatment. The Progress Notes dated 12/25/24 at 10:14 AM documented the facility was notified by the ED that R14 was admitted to the hospital with the diagnosis of right hip fracture. The Progress Notes dated 12/25/24 at 11:14 AM documented the facility was notified by the ED that R14 was scheduled for surgery the following day. The Progress Notes dated 12/30/24 at 12:00 PM documented R14 returned to the facility after a partial right hip replacement. Review of the facility's fall investigation dated 12/25/24 revealed R14 had a fall with major injury. The facility's root cause analysis determined R14 was ambulating without assistance. The resident's Care Plan lacked an intervention related to the fall on 12/25/24. The Progress Notes dated 01/30/25 at 06:34 PM documented R14 was found with the upper half of his body on the bed with his lower body off the bed with right knee resting on the floor. The facility lacked a fall investigation report for the fall on 01/30/25 with root cause analysis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident's Care Plan lacked an intervention related to the fall on 01/30/25. During an observation on 03/12/25 at 02:41 PM, R14 was seated in a wheelchair in the common area with peers present. R14's right leg rested on the foot pedal of the wheelchair in a semi-extended position with knee-immobilizer observed on right leg. Roll-back brakes and pressure alarm observed on R14's wheelchair. During an interview on 03/13/25 at 09:37 AM, CNA J revealed if a resident was on the floor, she would ask the resident why they were on the floor. If the resident stated that they were not on the floor by their choice then it was considered an unwitnessed fall, and the nurse would be notified. During an interview on 03/13/25 at 09:51 AM, Certified Medication Aide (CMA) H revealed a fall is defined as a change in plane (standing to seated, seated/laying to ground). CMA H revealed if a resident fell, staff would notify the nurse and follow the nurse's instructions. During an interview on 03/13/25 at 01:22 PM, Licensed Nurse (LN) G revealed after a fall, the resident was assessed, a fall packet was completed which included root cause analysis and development of an intervention to put in place and a new intervention on the permanent care plan. The nurse would then communicate the change verbally to the staff on shift and communicate to oncoming shifts with the communication book. During an interview on 03/03/25 at 01:32 PM, Administrative Nurse C revealed that a fall is defined an unintentional change in plane. Administrative Nurse C confirmed the lack of care plan interventions for R14's 07/09/24, 09/02/24 and 11/16/24 falls. Administrative Nurse C revealed that the immediate intervention for the 12/25/24 fall was one-on-one observation and support until EMS arrived and confirmed that it was not documented in the fall investigation report. Administrative Nurse C confirmed the progress noted dated 01/30/25 should have initiated a fall investigation since the resident had a change in plane. Administrative Nurse C revealed that after a fall, the nurse completed the fall packet which was then routed to her and she would investigate the fall with the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.). The IDT team met weekly and would determine the appropriateness of interventions and would also to evaluate if additional interventions are required specific to that fall. Administrative Nurse C revealed that she would also consult with Administrative Nurse B about falls more frequently than the weekly IDT meetings. The facility's undated Fall Prevention Protocol policy documented each elder would be provided services and care that ensured that the environment remained as free of accident hazards as possible. Each elder would receive adequate supervision and assistive devices to prevent accidents. The facility's undated Accidents and Incident Policy policy documented the facility was committed to provide a safe and secure environment which included fall prevention. Staff would implement fall prevention strategies based on individual assessments and provide assistive devices in areas where falls were more likely to occur. Additionally, all staff would follow facility procedures for fall investigations The facility failed to implement fall prevention interventions after multiple falls for cognitively impaired R14, with a known history of repeated falls. R14 had a fall with minor injury on 07/09/24, a fall without injury on 09/02/24, and a fall with minor injury on 11/16/24 with no fall prevention interventions identified and implemented to prevent further falls. On 12/25/24, R14 fell and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fractured his right hip which required hospitalization and surgical repair. On 01/30/25, R14's lower body was found on the floor, with upper body in bed, the facility failed to investigate this as a fall. - Review of the Electronic Health Record (EHR) for Resident (R) 9 included diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and repeated falls. The 11/20/24 Quarterly MDS documented the BIMS score of 14, which indicated intact cognition. The assessment documented R9 utilized a wheelchair for locomotion and required partial/moderate assistance with bathing, supervision/touching assistance for oral and toileting hygiene, setup/cleanup assistance for all other cares except personal hygiene which was performed independently. The assessment documented two or more non-injury falls since the previous assessment. R9 received dialysis and oxygen. The 02/12/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The assessment documented R9 utilized a wheelchair for locomotion and required partial/moderate assistance with bathing, supervision/touching assistance for oral and toileting hygiene, setup/cleanup assistance for all other cares except personal hygiene which was performed independently. The assessment documented two or more non-injury falls since the previous assessment. R9 received dialysis and oxygen. The Falls Care Area Assessment (CAA) dated 01/12/25, documented most of R9's falls occurred on evenings after dialysis. The 02/18/25 Care Plan, reviewed 03/12/25, documented on 03/09/22 R9 was at risk for falls related to history of falling and included the following interventions: On 03/09/22, when staff passed by R9's room, they would ensure she was in the center of her bed to prevent falls and encourage proper bed alignment. Staff would place non-skid strips on the floor where transfers occur, keep personal and frequently used items and call light in reach at all times. Staff would also encourage R9 to change positions slowly and make sure wheelchair was locked before getting out of bed. Staff would also encourage and assist R9 to remove all extra pillows and stuffed animals off of the bed before getting into the bed. On 03/13/22, staff educated R9 to lock both brakes on her wheelchair before self-transfers. On 08/10/22, staff would place a pillow beside R9 while in bed during the day to remind her where the edge of the bed was. On 10/17/22, staff would keep R9's bed at knee-height and wheel chair locked and next to the bed for safe transfers. On 12/20/22, R9 was high fall risk. On 06/23/23, staff would encourage R9 to have the wheelchair closer to the recliner prior to transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/25/24, staff would place non-skid strips on the floor in front of the recliner to help prevent feet from sliding. On 04/05/24, staff would assist R9 to ensure proper footwear, either shoes or non-skid socks. On 04/10/24, staff would rearrange R9's bathroom to be free of clutter and provide more room for additional independence in the bathroom. Staff would also analyze R9's fall to determine a pattern or trend. On 11/27/24, staff would ensure R9 wore slipper socks when not wearing shoes. On 01/09/25, staff would provide R9 with verbal reminders to not ambulate (walk) or transfer without assistance. On 03/08/25, staff would ensure R9 wore her oxygen at all times. Review of Observations in the EHR documented R9 was at risk for falls on 05/29/24, 06/14/24, 08/20/24, 08/23/24, 11/19/24, 11/28/24, 01/09/25 and 02/11/25. The EHR lacked a fall risk assessment after the non-injury fall on 08/23/24. The Progress Note dated 08/23/24 at 03:38 AM documented R9 had a fall without injury. R9 was found by staff on the floor in front of the recliner and was in a seated position. Review of the facility's fall investigation revealed R9 had a fall without injury on 08/23/24. The facility's root cause analysis determined R9 removed the dycem (a non-slip mat used for stabilization and gripping to prevent slipping) from her recliner. The resident's Care Plan lacked an intervention related to the fall on 08/23/24. The Progress Note dated 08/30/24 at 02:40 AM documented R9 had a fall without injury. R9 was found by staff on the floor in front of the recliner and was in a seated position. Review of the facility's fall investigation revealed R9 had a fall without injury on 08/30/24. The facility's root cause analysis determined R9 was not wearing non-skid socks and did not use her call light for assistance. The resident's Care Plan lacked an intervention related to the fall on 08/30/24. During an interview on 03/13/25 at 09:37 AM, CNA J revealed if a resident was on the floor, she would ask the resident why they were on the floor. If the resident stated that they were not on the floor by their choice then it was considered an unwitnessed fall, and the nurse would be notified. During an interview on 03/13/25 at 09:51 AM, Certified Medication Aide (CMA) H revealed a fall is defined as a change in plane (standing to seated, seated/laying to ground). CMA H revealed if a resident fell, staff would notify the nurse and follow the nurse's instructions. During an interview on 03/13/25 at 01:22 PM, Licensed Nurse (LN) G revealed after a fall, the resident was assessed, a fall packet was completed which included root cause analysis and development of an intervention to put in place and a new intervention on the permanent care plan. The nurse would (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	then communicate the change verbally to the staff on shift and communicate to oncoming shifts with the communication book. During an interview on 03/03/25 at 02:15 PM, Administrative Nurse C revealed that a fall is defined an unintentional change in plane. Administrative Nurse C confirmed the lack of care plan interventions for 08/23/24 and 08/30/24 falls. Administrative Nurse C revealed that after a fall, the nurse completed the fall packet which was then routed to her and she would investigate the fall with the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.). The IDT team met weekly and would determine the appropriateness of interventions and would also to evaluate if additional interventions are required specific to that fall. Administrative Nurse C revealed that she would also consult with Administrative Nurse B about falls more frequently than the weekly IDT meetings. The facility's undated Fall Prevention Protocol policy documented each elder would be provided services and care that ensured that the environment remained as free of accident hazards as possible. Each elder would receive adequate supervision and assistive devices to prevent accidents. The facility's undated Accidents and Incident Policy policy documented the facility was committed to provide a safe and secure environment which included fall prevention. Staff would implement fall prevention strategies based on individual assessments and provide assistive devices in areas where falls were more likely to occur. Additionally, all staff would follow facility procedures for fall investigations The facility failed to implement fall prevention interventions after multiple falls R9, with a known history of repeated falls. R9 had a fall without injury on 08/23/24 and 08/30/24 with no fall prevention interventions identified and implemented to prevent further falls. - Review of the Electronic Health Record (EHR) revealed that Resident (R)10 included diagnoses of Paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), auditory hallucinations (sensory experiences of hearing sounds or voices that are not present in the external environment), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), restless legs syndrome (a neurological disorder characterized by an irresistible urge to move the legs, often accompanied by unpleasant sensations such as tingling, crawling, or aching), cognitive communication deficit (communication difficulty arising from impaired cognitive processes like attention, memory, or reasoning, rather than a primary language or speech problem), chronic pain syndrome (a condition characterized by persistent pain that lasts at least three months), unspecified systolic (congestive) heart failure (a condition where the heart's left ventricle doesn't pump blood effectively, leading to symptoms like shortness of breath, fatigue, and swelling), and developmental disorder of speech and language (a neurodevelopmental condition that significantly impacts a child's ability to learn, understand, and use language, affecting their speaking, listening, reading, and writing skills). The 05/27/24 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R10 was dependent on staff assistance for toileting hygiene and bathing and required substantial to maximum assistance for upper clothing dress while being totally dependent for lower body dress and footwear. The 05/27/24 Activity of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA), documented R10 was dependent on staff for cares, and he required staff assistance and full lift (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	for all transfers. The 05/27/24 Falls CAA, documented R10 was a high risk for falls related to being wheelchair bound, was unable to use a transfer board, and required the use of full lift for transfers. The 02/19/25 Quarterly MDS, documented a BIMS score of 12 which indicated moderately impaired cognition, and documented no falls since the previous assessment. The assessment documented R10 could feed self with no swallowing problems. The MDS indicated R10 was dependent on staff assistance for toileting hygiene and bathing and required substantial to maximum assistance for upper clothing dress while being totally dependent for lower body dress and footwear. The Care Plan, documented on 11/02/24 R10 was at risk for falls due to intermittent confusion and required a total lift for transfers. R10 did not have the ability to ambulate independently due to paraplegia and included the following interventions: On 11/02/24, staff would reposition the bed in the room. On 11/02/24, Occupational Therapy (OT) (helps people of all ages improve their ability to perform daily activities and participate in meaningful occupations by addressing physical, cognitive, and social challenges) to evaluate R10 for use of a trapeze (provides a person a means of self-help to change position in bed, to move onto a bedpan, to move from a bed to a commode, or to transfer to and from a wheelchair with minimal help from an attendant). The Progress Notes dated 11/02/24 at 11:08 AM, documented R10 was found on his floor and indicated R10 had a fall. The Progress Notes dated 03/07/25 at 10:55 PM, documented R10 slid down his wheelchair while being transferred from the wheelchair to the bed but made no impact on any surfaces. During an interview on 03/11/25 at 03:10 PM, R10 reported he slipped out of the front of his wheelchair recently while transferring and landed on the floor. During an interview on 03/13/25 at 09:37 AM, Certified Nurse Aide (CNA) J stated if resident was sitting on the floor she would first ask (if BIMS allows) why they were on the floor, and if not by choice she would then notify the nurse for assessment. CNA J said if the resident was not on the floor by choice it was considered an unwitnessed fall. CNA J said if she was assisting a resident from the wheelchair to the bed or toilet and they slipped, but did not land on the floor CNA J indicated that was not a fall. CNA J said she would still notify the nurse and help fill out an incident report. During an interview on 03/13/25 at 09:51 AM, Certified Medication Aide (CMA) H reported that a fall is a break in plane. CMA H stated that if a resident slides out of chair, but they're caught before hitting the floor and assisted back into the chair then it's the nurse discretion, the nurse would be notified, and they'd do what they do. CMA H indicated that she usually just tells the nurse. During an interview on 03/13/25 at 09:56 AM, Licensed Nurse (LN) G reported a fall was a difference in the center of gravity. LN G stated that if she caught a resident sliding out of a chair and assists them back into the chair, she would make a progress note about it, but said it was not considered a fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/13/25 at 10:59 AM, Administrative Nurse B stated a fall was any unplanned change in plane. Administrative Nurse B reported if staff caught a resident sliding out of their chair and assisted them back into the chair, it was not a fall, it was a prevented fall, and a fall packet was not done but it would be charted. Administrative Nurse B said for actual falls the nurse performed a full assessment, a fall packet was filled out and the Director of Nursing, Administrator, the resident's Durable Power of Attorney, and the Physician are notified. The facility's undated Sandstone Heights Falls Policy and Procedure documented that a resident who fell would be assessed by the charge nurse. The fall would be documented in the progress notes and a fall event would be completed. A licensed nurse would ensure that a fall or injury was assessed by a licensed nurse. The facility's undated Fall Prevention Protocol policy documented each elder would be provided services and care that ensured that the environment remained as free of accident hazards as possible. Each elder would receive adequate supervision and assistive devices to prevent accidents. The facility's undated Accidents and Incident Policy policy documented the facility was committed to provide a safe and secure environment which included fall prevention. Staff would implement fall prevention strategies based on individual assessments and provide assistive devices in areas where falls were more likely to occur. Additionally, all staff would follow facility procedures for fall investigations. The facility failed to implement fall prevention interventions after R10 had a fall on 03/07/25, with a known history of falls and failed to conduct an investigation after a staff intercepted fall.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 22 residents. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions for the residents of the facility. Finings included: - On 03/11/25 at 01:34 PM, kitchen tour with Dietary Aide (DA) K, revealed the following areas of concern: 1. Thirteen cookie sheets/pans with brown, dried, caked on substance on the exterior and the interior corners and cooking surfaces of each pan. Pans were in a upside down position, one on top of other, which resulted in the outside of one pan in direct contact with the cooking surface of the next pan. The surfaces were unsanitizable. 2. Seven frying pans/skillets with brown dried caked substance on exterior and interior corners and cooking surfaces were in a upside down position, one on top of other, the outside of one skillet/frying pan in direct contact with the cooking surface of the next skillet/frying pan. The surfaces were unsanitizable. 3. A metal rack with four shelves with rust and greasy sticky grim build-up on the upper which rendered them unsanitizable. 4. A refrigerator with two rolled up wet towels were inside the refrigerator on the bottom shelf. 5. Three empty open gallon white plastic container on the top shelf of the refrigerator. One of the uncovered, unlabeled, containers had an orange yellow substance covering the bottom of the container. 6. Six unlabeled and uncovered glasses of juice in the refrigerator. On 03/11/25 at 01:42 PM, Dietary Aide (DA) K, confirmed the above findings. She reported the cookie sheets/pans had always been that way that it was difficult to get the brown caked on food off the pans. She verified the brown substance on the pan would be in direct contact with the food during food preparation. Additionally, she stated the dietary staff placed towels and the open unlabeled white containers were placed in the refrigerator to catch the water that was dripping from the top of the refrigerator. Furthermore, the orange discoloration that was inside the open plastic container was from rust where the water dripped through the vent in the refrigerator. She stated the glasses of juice were for the residents and should be labeled and covered to prevent food borne bacteria from growing. On 03/13/25 at 11:09AM, Dietary Manager (DM) E confirmed above findings related to food storage, labeling, and sanitation. She reported she informed the staff to clean and get rid of towels in the refrigerator due to contamination and possible food born bacteria could grow on the damp surface. DM e stated the containers had an orange substance in them because the staff failed to clean them as they should. Confirmed 13 cookie sheets remain inverted on shelfing with brown substance. She reported the pans and skillets, had been like that since her employment. She stated the only way to get (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175509	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Heights	440 State Street Little River, KS 67457

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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 - Few	cookie sheets clean to replace them. She confirmed the towels should not be kept inside the refrigerator and food/drinks should be covered and labeled to prevent contamination and food borne illnesses. The undated facility policy titled Food Preparation and Handling Policy, documentation included cross contamination as the transfer of harmful substances or diseas causing microorganisms by hands, food contact surfaces, sponges, and cloth towels. Food items will be prpared using methods designd to be free of injurious organisms and substances. The facility failed to store and prepare food under sanitary conditions for the residents of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175509	A. Building B. Wing	03/13/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility reported a census of 22 residents. Based on interview and record review, the facility failed to electronically submit complete and accurate staffing information to the Federal regulatory agency through Payroll-Based Journaling (PBJ) when the facility failed to accurately submit hourly staffing data for all nursing personnel. Findings included: - Review of the PBJ Staffing Data Report for Fiscal Year (FY) for Quarter 1 - 2024 (October 1 - December 31), revealed the facility failed to have Licensed Nursing Coverage 24 hours/Day on the following dates: 10/14/24 Saturday (SA), 10/20/24 Friday (FR), 10/21/24 Saturday (SA), 10/22/24 Sunday (SU), 10/28/24 Saturday (SA), 11/19/24 Sunday (SU). Review of the Nursing Schedule and Payroll Data Sheets for the above dates revealed the facility had 24-hour nursing coverage. During an interview on 03/12/25 at 11:15 AM, Administrative Nurse B confirmed the facility had 24-hour nursing coverage, even though it was not reflected on the PBJ report. On 03/12/25 at 12:45 PM, Administrative Nurse B provided payroll staffing data for the dates in question. The facility failed to provide a Payroll Based Journal Policy policy. The facility failed to submit complete and accurate staffing information to the Federal regulatory agency through PBJ when the facility failed to accurately submit hourly staffing data for all nursing personnel.