STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175521	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wheatlands Health Care Center	750 W Washington St Kingman, KS 67068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility reported a census of 45 residents with 12 residents sampled. Based on interview, observation, and record review, the facility failed to protect the privacy and dignity of Resident (R) 24, who stood in her room partially dressed in pants and an undergarment, when a staff member walked by R24's room, looked into R24's room and continued to walk down the hallway without intervening. This practice had the potential to lead to negative psychosocial effects related to dignity. Findings included: - The Electronic Health Record (EHR) included the diagnoses of major depressive disorder (MDD - a major mood disorder which causes persistent feelings pf sadness) and dementia (a progressive mental disorder characterized by failing memory, confusion). The 05/13/24 Significant Change Minimum Data Set (MDS) documented R24 had a Brief Interview of Mental Status score of 12, which indicated moderately impaired cognition. The assessment documented R24 required supervision/setup assistance with bathing, eating, and oral hygiene and was otherwise independent with cares. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 05/13/24 documented R24 was alert and oriented to person/place/time with moments of confusion and disorientation. The Quarterly MDS dated 11/13/24 documented a BIMS score of nine which indicated moderately impaired cognition. The MDS documented R24 required partial/moderate assistance with bathing and toileting; supervision/touching assistance with dressing, footwear application, and personal hygiene; and setup assistance with oral hygiene and eating. The Care Plan, reviewed 12/03/24, documented an intervention dated 12/18/23 that staff should pull the curtain for privacy and dignity in the shower room but lacked additional interventions specifically related to privacy or dignity. On 12/03/24 at 12:10 PM, R24 observed standing in her room wearing pants and an undergarment, and visible from the hallway with the door to her room open. On 12/03/24 at 03:36 PM, R24 stated that staff sometimes left the door open when providing her cares or when she was getting dressed, and this bothered her. On 12/03/24 at 12:10 PM, Housekeeping Staff P walked by R24's room, looked into R24's room and continued to walk down the hallway, without closing her door. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 12:16 PM, Housekeeping Staff P confirmed R24 was standing in her room and was only wearing an undergarment above the waist with the door to her room open, and confirmed she should have closed the door and alerted nursing staff, that the resident might require assistance. On 12/03/24 at 12:22 PM Certified Medication Aide (CMA) W stated if a resident was observed from the hallway wearing only undergarments, the first step would be to close the door to protect the resident's privacy and dignity and then assist if needed. On 12/03/24 at 03:00 PM Certified Nurse Aide (CNA) O stated if a resident was observed from the hallway only wearing undergarments, staff should close the door to protect the resident's privacy and dignity and assist as needed. On 12/03/24 at 03:43 PM, LN N revealed that if a resident was observed in their room wearing only undergarments the first thing staff should do is to close the door, then provide whatever assistance that may be required. On 12/03/24 at 03:53 PM, Administrative Nurse B stated the facility expected all staff to provide dignity by closing the door if a resident was discovered partially dressed in their room. Administrative Nurse B confirmed that staff walking by R24's room and seeing the resident partially dressed and failed to close the door, was a dignity concern. The facility's Right to Dignity policy, dated 10/2024 documented the facility would promote care in a manner and environment that maintains and enhances dignity and respect. The facility failed to protect the privacy and dignity R24 who stood in her room wearing pants and her undergarment, and a staff member walked by R24's room, looked into R24's room, and continued to walk down the hallway without intervening. This practice had the potential to lead to negative psychosocial effects related to dignity.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 45 residents, with 12 residents sampled, and one resident reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, interviews, and record review, the facility failed to provide a pressure reducing device on the bed to prevent a pressure injury for Resident (R) 9. Additionally, the facility utilized the incorrect size full body sling when transferring R9 in and out of bed with the mechanical lift. Findings included: - Resident (R)9 's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and muscle weakness. The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 11, which indicated moderately impaired cognition. R9 required total assistance with activities of daily living (ADL), which included toileting, transfers, bathing, and wheelchair mobility. R9 required maximal assistance with bed mobility, hygiene, dressing, footwear, and oral care. R9 was always incontinent of bladder. The Pressure Ulcer Care Area Assessment (CAA) dated 11/01/24, documented R9 had an open area to her back. R9 had an air mattress and cushion to her recliner and wheelchair. The CAA included the wound would be assessed weekly by administrative wound care nurse and noted she was currently on a repositioning schedule. The Urinary Incontinence and Indwelling Catheter CAA dated 11/01/24, documented R9 was incontinent of bowel and bladder, wore adult briefs, and was dependent on staff for toileting hygiene and toileting needs. R9 refused to toilet in the bathroom and requested staff change her brief when it was soiled. The Admission MDS dated [DATE], documented the resident had a BIMS of 14, which indicated intact cognition. The MDS noted required maximum assistance with upper body dressing and required total assistance with bed mobility, transfers, and toileting. R9 was always incontinent of bladder. The MDS indicated R9 had a stage two pressure (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) ulcer on admission, and no pressure reducing device on bed or chair. The Pressure Ulcer CAA dated 08/22/24, documented R9 admitted with a healing stage two pressure ulcer. The resident's Care Plan included the following interventions: 08/14/24 - Staff instructed to turn and reposition totally dependent R9 every two hours and as necessary. R9 required a full body lift sling and mechanical lift for all transfers with assistance of two staff members. The staff were to avoid positioning the resident on her bottom for long periods of time and try to limit time up in her wheelchair to less than two hours. The staff were to monitor, document, and report any changes in skin status appearance, color, and wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/14/24, revised 11/25/24 - Staff instructed that R9 required a pressure reducing cushion in her wheelchair and recliner. The staff were to offload her back with a blanket or pillow when in her wheelchair or recliner, and to leave her bed as flat as possible, to reduce shear. 10/23/24 - Staff instructed to provide protein shakes twice a day for wound healing. 12/02/24 - Staff instructed to provide Juven (a therapeutic nutrition drink mix powder designed to support tissue building and collagen formation in the dietary management of wounds) as per ordered. Review of the Physician Orders documented the following orders: 08/14/24 order for the history of stage two pressure injury to right buttock: keep skin clean and dry after each incontinence episode apply moisture barrier or calmoseptine cream (is used to protect skin from wetness, urine, or stools); Notify the nurse of worsening or changes in healed area. 08/14/24 order for the resolved pressure ulcer to right buttock, staff were to monitor every morning and at bedtime, apply moisture barrier after each incontinent episode, and ensure the pressure reducing cushion was utilized in her wheelchair and recliner and reposition every two hours. 10/15/24 order to offload the wound to the residents left lower back when in bed. Educate and remind staff on every shift to use caution when placing or removing full sling lift. Pad full sling with soft blanket between resident and sling. 10/21/24 order for staff to monitor dressing to left lower back to ensure dressing is intact. If overly soiled or no longer intact change dressing as ordered. 11/25/24 order for staff to cleanse the wound to left back with wound cleanser, pat dry and apply skin prep (liquid skin protectant) around the wound. Apply collagen (a protein that plays a key role in the body's wound healing process) to wound bed, cut calcium alginate (a non-adhesive, absorbent wound dressing) to fit over wound bed. Apply a foam pad with approximate 2 centimeter circle cut out (goal is to offload pressure to area) then cover with large Opti foam (a medical-grade foam dressing used for wound care) dressing. Change every other day and as necessary. 11/25/24 order to offload wound to the left lower back, use pillows while in bed and soft blankets while up in wheelchair. The Skin Assessment dated 08/14/24 at 03:52 PM documented, R9 had a healing stage two pressure ulcer to her right buttock, which measured approximately 2 centimeters (cm) by 2 cm, with pink new dermal (the thick layer of living tissue below the outer layer of skin) tissue. Review of the Skin Assessments dated 08/16/24 through 12/03/24 lacked further documentation of the right buttock healing stage two pressure ulcer and the wound on resident's left lower back. Review of EHR from 08/14/24 through 10/13/24 lacked any Skin-Wound Notes (a template used by Administrative Nurse G/Wound Nurse template to monitor skin concerns). The Skin-Wound Note dated 10/14/24 at 03:09 PM documented staff reported an abrasion on R9's left lower back. The note included the area looked like it could be from the full body sling. The wound measured 1.5 cm by 1 cm, with 0.1 cm in depth. The wound bed was 80 percent slough (dead tissue, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually cream or yellow in color) and 20 percent pink tissue, and noted the staff updated the provider and received new orders. The Skin-Wound Note dated 10/21/24 at 09:25 AM documented wound measured 1.3 cm by 1 cm, with 0.2 cm in depth. The wound bed is 90 percent slough and 10 percent pink tissue. The note included a discussion with R9 to try a different wheelchair and a pressure reducing air mattress, and staff were educated to provide a soft blanket between the resident and the full body sling. The Skin-Wound Note dated 10/29/24 at 08:14 AM documented hospice notification and will provide a high back wheelchair for wound healing and positioning. The Skin-Wound Note dated 11/04/24 at 07:14 AM documented wound measured 1 cm by 1 cm, with 0.2 cm depth, wound bed was 20 percent slough and 80 percent pink tissue. R9 reported she did not like the high back wheelchair and air mattress and requested to have a different mattress and wheelchair provided by hospice. The Skin-Wound Note dated 11/18/24 at 12:41 PM documented the wound on the left lower back measured 1cm by 0.8 cm, by 0.2 cm in length, and the wound bed was 70 percent slough and 30 percent pink tissue. The Skin-Wound Note dated 11/25/24 at 10:03 AM documented the wound to the left lower back was obviously over a bony prominence. The wound had worsened and measured 1.5 cm by 1 cm, with 0.2 cm depth. The wound bed was 80 percent slough and 20 percent red tissue, with serosanguinous (semi-thick blood-tinged) drainage noted on the removed dressing. R9 declined an air mattress and continued on a turn and reposition program, every two hours and as needed. The staff updated the provider and received new orders. The Skin-Wound Note dated 12/02/24 at 11:08 AM documented the wound on the left lower back measured 1.5 cm by 2.5 cm, with 0.1 cm depth. The wound bed was 90 percent slough and 10 percent eschar (dead tissue), and the wound had an odor and moderate amount of purulent (producing or containing pus) drainage, with a wound culture obtained. R9 was started on Doxycycline (an antibiotic used to treat infections) 100 milligram capsule, one capsule by mouth for seven days. During an observation on 12/03/24 at 08:44 PM, Certified Nurse Aide (CNA) S and Certified Medication Aide (CMA) CC assisted R9 to bed from her wheelchair. CNA S and CMA CC utilized the mechanical lift, R9 had a full body mesh sling with a light blue binding around the edge of lift. The sling was observed to be an extra-large Invacare sling. R9 held onto the bar of the lift, the sling was noted to be quite large, the top of the sling was hanging over R9's head on her face near her eyes and the bottom of the sling was near R9's knees. During an observation on 12/03/24 at 08:53 PM, Licensed Nurse (LN) R administered treatment to R9's wound on the left lower back. LN R reported the area on R9's left lower back was approximately 2.5 cm by 3 cm. Observed a moderate amount of purulent drainage on the removed wound dressing. There was approximately 90 percent slough and 10 percent eschar noted on the wound bed. The wound was over a bony prominence and surrounding the wound was redness that was blanchable (to press on a person's skin to push blood away and wait for return to determine blood circulation). During an interview on 12/03/24 at 09:00 AM, CMA CC reported that care plans do not include what size or type of sling to use when transferring a resident with a mechanical lift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/24 at 09:00 AM CNA S reported the staff just grab a sling from linen closet to use if resident did not have one in their room. CNA S reported she thought the sling that was used with R9 was the correct size. CNA S reported that she was not trained to use a sling by size and did confirm the sling covered R9's head to her eyes. During an interview on 12/03/24 at 09:40 AM, Administrative Nurse H reported that she would not care plan the size or what type of sling to use for transfers with a mechanical lift. She reported that the facility did not use weight or height of a resident to determine what sling to use. Administrative Nurse H reported that R9 had lost weight since admission and that the same sling is being used. She also reported that if the staff used a bigger sling, the resident would be safer than using a smaller sling. During an interview on 12/03/24 at 11:30 AM, Administrative Nurse G reported that the area on R9's left lower back was indeed a pressure area. Administrative Nurse G reported that after R9 had lost weight, the area was noted over a bony prominence. Administrative Nurse G reported when the area was first noted in October 2024, it appeared to be from the full body sling as shearing when staff removed the sling or pulled on the sling to position R9. She reported that R9 did not like the air mattress and preferred her head bed elevated and not to lay flat. During an interview on 12/04/24 at 08:45 AM, Consultant Staff DD Occupational Therapist reported that therapy did not decide what sling size to use for mechanical lifts. Consultant Staff DD reported the staff use what sling is available. He did report that the weight rating should be on the slings and confirmed that an extra-large Invacare sling for a resident that weighed 154 pounds, was too big of a sling and could cause an unsmooth surface and shearing of skin. During an interview on 12/04/24 at 10:30 AM, CNA V, CMA L, and CNA M reported the sling in the residents' room was the sling they used. They all reported they did not realize the slings came in different sizes and the sling had a tag to state what size it was. During an interview on 12/04/24 at 10:40 AM, CMA X reported she did not realize slings had different sizes and the sling under R26 was illegible. She reported the staff just grabbed a sling and used it. However, she would position the sling from the resident's head to below the resident's buttocks. During an interview on 12/05/24 at 11:14 AM, Administrative Nurse B reported she did not realize the mechanical lift slings were different sizes. Additionally, she did not realize that Invacare had a warning in the manual to use the Invacare slings for the Invacare lifts. She reported that staff would look at the resident's size to determine the appropriate sling to use. Administrative Nurse B confirmed that the facility does purchase slings from other companies and the sling used for R9 was too large for her. During an interview on 12/05/24 at 01:55 PM, Administrative Nurse G reported the air mattress for R9 was placed on her bed on 10/29/24 and was removed on 11/18/24 per R9's request. She confirmed that the air mattress was not placed on the care plan but did show the documentation on PCC under the tasks charting. She also reported that R9 was admitted on [DATE] and had a healing pressure ulcer on right buttock and did not require skin wound notes. Review of the facility's Invacare Manual undated revealed a warning: slings and accessories designed by other manufactures are not to be utilized as a component of the Invacare lift system. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pressure Ulcer Prevention policy dated 09/2024 documented the following: To provide care and services to promote good skincare and to prevent pressure ulcer development. The facility failed to place interventions to prevent pressure injuries for R9, who developed one preventable, facility acquired, unstageable pressure injury. This placed the resident at risk to worsen his current pressure ulcer or develop more skin issue. - Review of the Electronic Medical Record (EMR) R26, included diagnoses of hypertension (HTN- elevated blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), obesity (excessive body fat), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and polyneuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet). The 01/10/24 Significant Change Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. R26 had behaviors which included delusions, and verbal behavioral symptoms directed towards others t interfered with his care, disrupted the living environment. He rejected care and wandered. R26 used a walker and wheelchair and required partial to moderate assistance with bed mobility and transfers. He required substantial to maximal assistance with toileting hygiene and was dependent on staff with wheelchair mobility. He was frequently incontinent of urine and always incontinent of bowel. The MDS documented two or more noninjury falls and one injury fall. Review of the Falls Care Area Assessment (CAA) dated 01/10/24, identified R26 required staff assistance. R26fell three times in two days, which caused injuries due to frequent attempts to self-transfer. He required assistance of two staff with transfers and toileting needs. Review of the Cognitive Loss/Dementia (CAA) dated 01/10/24, identified R26 had a diagnosis of dementia. The 10/8/24 Quarterly MDS documented a staff interview, which indicated the resident had long term and short-term memory problems. He was always incontinent of urine and frequently incontinent of bowel. He was dependent on staff for transfers, toilet hygiene, and mobility. He had one injury fall documented. Review of the resident's Care Plan on 12/02/24 revealed the following interventions: 12/28/21- R26 was at high risk for fall due to being unaware of his safety needs. Interventions at that time to anticipate his needs and have the call light in place. 01/07/24 - Staff would know the resident was not to be left unattended in the bathroom. Staff could stand outside the door with it being ajar for the resident's privacy. 07/26/24 - The facility provided staff education on following resident care plans. Review of the Nurses Notes on 07/26/24 at 07:00 PM document R26 unhooked his sit to stand sling and sat himself on the floor beside the toilet. No injuries were noted. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fall Packet dated 07/26/24 revealed staff completed a root cause analysis and found that staff needed education on the resident's care plan and the facility provided education as an intervention for the fall. During observation on 12/03/24 at 01:32 PM, CMA BB and CNA X transferred R26 with full body mechanical lift using a sling with yellow around the edge. During an interview on 12/04/24 at 01:15 PM, CMA AA reported staff were aware they could not leave any resident unattended and attached to any lift. During an interview 12/04/24 at 01:15 PM, Licensed Nurse (LN) R reported staff were aware they could not leave any resident unattended and attached to any lift. During an interview on 12/04/24 at 01:22 PM, Administrative Nurse B revealed R26 had a fall after being left on the toilet and attached to the sling with no staff present. Staff returned later to find him on the floor. Administrative Nurse B confirmed staff did not follow the resident's care plan and that additional training was needed. The facility's Safe-Lift policy dated 10/24 documented for staff to use mechanical lift devices in accordance with instructions and training. The facility failed to implement effective fall prevention interventions to prevent falls for cognitively impaired R26, who had repeated falls. - Review of the Electronic Medical Record (EMR) for R26 included diagnoses of hypertension (HTN-elevated blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), obesity (excessive body fat), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), polyneuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), cellulitis of the toes (skin infection caused by bacteria). The 01/10/24 Significant Change Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident had a total mood severity score of 0, which indicated no depression. R26 had behaviors which included delusions, and verbal behavioral symptoms directed towards others that interfered with his care and disrupted the living environment. He rejected care and wandered. R26 used a walker and wheelchair and required partial to moderate assistance with bed mobility and transfers. He required substantial to maximal assistance with toileting hygiene and was dependent on staff with wheelchair mobility. He was frequently incontinent of urine. The MDS identified R26 as at risk for pressure ulcers. No pressure related skin issues were identified on the assessment, and he had a pressure reducing device for his chair. The 01/10/24 Pressure Ulcer/Injury Care Area Assessment (CAA) stated R26 had trace edema to both legs but did not wear any compression socks as he preferred to wear regular shoes and socks. A care plan would be initiated to address skin impairment of the lower legs. The assessment identified that he was incontinent, had no pressure areas, and used a cushion to his wheelchair. The 10/08/24 Quarterly MDS documented a staff interview for cognition, which indicated long term and short-term memory problems. He did not know the season, room location, staff, or that he was in a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing home. The resident had a total mood severity score of 0, which indicated no depression. He had no hallucinations or delusions. He was always incontinent of urine and frequently incontinent of bowel. The assessment documented the resident was on a toileting program. The MDS documented he had difficulty with meals, lost food from his mouth when he ate, held food in his mouth, and coughed with meals. He had a stage two pressure ulcer, was on a turning and repositioning program and had a pressure reliving device for his wheelchair. Review of the resident's Care Plan on 12/02/24 revealed the following interventions: 04/11/24 - staff were to turn and reposition the resident every two to four hours. 09/04/24 - staff were to turn and reposition the resident at least every two hours and more often as needed or requested, because he was dependent on staff for repositioning. 09/04/24 - Staff would know R26 was dependent on two staff for repositioning and turning in bed as necessary. 09/04/24 - R26 required assistance with meals. Review of the resident's Physician Orders dated 08/22/24 revealed R26 had an order to Offload bottom throughout shift. Do not keep resident up in wheelchair for prolonged periods of time. Review of the resident's Tasks on 12/02/24 revealed R12 had a task for Certified Nurse Aides (CNA)s to record turning and repositioning every two hours. On 12/03/24, Certified Medication Aide (CMA) BB recorded that she turned and repositioned R26 at 08:00 AM, 10:00 AM, and 12:00 AM. Review of the Medication Administration Record (MAR) for December 2024 revealed staff documented they followed the order to offload the resident's bottom every shift and to not keep the resident up in the wheelchair for prolonged periods of time on every shift. Review of the resident's Braden Assessment dated 10/08/24 revealed R26 had a score of 12, which indicated a high risk for pressure ulcers. Review of the resident's Skin Assessment on 12/02/24 revealed and area to his coccyx, which was treated with preventative cream and areas to his toes which were treated as ordered. Review of the Skin /Wound Notes dated 08/19/24 at 09:24 AM revealed the resident had a dark, red, non-blanchable area to his right upper buttocks that measured 3 centimeters (cm) x 2.5 cm. A treatment was initiated, and staff were to offload as much as possible. A turning and repositioning schedule was documented as already in place. Staff were educated on offloading the resident bottom. The residents nutritional supplement increased to three times daily to help with meeting nutritional needs/wound healing. Review of the Skin/Wound Notes dated 11/25/24 at 09:30 AM revealed the resident had a non-healing pressure ulcer with eschar to the tip of right great toe that measured 0.5 cm x0.5 cm, which presented as [NAME] ar (dead tissue). The area on the tip of left great toe remained resolved. Observation on 12/03/24 at 08:03 AM revealed R26 sitting in the dining room in his broda chair (specialized wheelchair with the ability to tilt and recline) with his feet dangled six inches off the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor. Observation on 12/03/24 at 08:48 AM revealed staff approached R26 in the dining room and did not offer repositioning at this time. Observation on 12/03/24 at 09:21 AM revealed the resident remained in same position. Observation on 12/03/24 at 10:20 AM revealed staff provided the resident with food but did not offer to reposition him at this time. Observation on 12/03/24 at 10:28 AM revealed the resident fidgeted in his chair and moved his bottom around. A facial grimace was noted with movement. As the resident continued to lean forward and fidget staff made no attempt to reposition him. Observation on 12/03/24 at 10:48 AM revealed the resident continued to fidget in his chair, move his bottom, and grimace, but remained in the same position. Observation on 12/03/24 at 11:09 AM revealed a staff member requested assistance from another staff member to reposition R26 up in the wheelchair. The staff members lowered the back of the resident's chair and slid him up in the wheelchair. Observation on 12/03/24 at 12:18 PM revealed R26 continued to fidget and slid down in his wheelchair. CNA X asked another staff member to assist her to lift him up in the chair. They repositioned him and she continued to assist him with his lunch. Observation on 12/03/24 at 01:30 PM surveyor asked for R26 to be taken to his room. Skin assessment completed with Licensed Nurse (LN) R. LN R identified a pea sized black eschar on the right great toe. When the resident's brief was removed there was a dark red line on his gluteal fold where his brief elastic was with blanchable redness surrounding it. The nurse applied firm pressure to the area and the darker line did not lighten. The area around did lighten and then returned to red. Staff finished changing R26 and did not place barrier cream on the resident during this observation. During an interview on 12/03/24 at 01:29 PM, CNA X revealed that R26 did not have a wheelchair cushion, and they elevated his feet so he could not touch the ground to keep him from walking. CNA X stated, If his feet touch the ground, he thinks he can walk, and we can't pick him up. When shown how his calf hit the bottom of the leg rest on the chair and dangled off, she informed the surveyor that there was not another part of the chair for his legs to rest on. During an interview on 12/03/24 at 01:29 PM, CNA X revealed that staff were aware R26 required frequent repositioning. During an interview on 12/03/24 at 05:28 PM, Certified Medication Aide (CMA) AA revealed staff did not know R26 had a footrest and stated they had not been using it. Another staff member found the footrest and applied it to the wheelchair when it was found. During an interview on 12/04/24 at 08:43 PM, CMA Y stated they followed the plans of care for the residents and staff were aware of how to look at the residents' care plan. During an interview on 12/04/24 at 11:19 AM, LN R revealed staff knew how to read the care plan and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff were aware R26 required frequent repositioning. During an interview on 12/04/24 at 02:47 PM, Administrative Nurse G revealed she was not aware that R26 had previous skin issues on his buttock, but that it was an expectation to provide repositioning and not to leave any residents in a wheelchair with feet dangling. During an interview on 12/04/24 at 05:00 PM, Administrative Nurse A stated it was her expectation that the chair would have a pressure relieving cushion. She also had an expectation that staff would not leave a resident without repositioning for a long amount of time. The facility policy Pressure Ulcer Prevention last reviewed on 09/2024 documented that staff would implement appropriate pressure reducing measures which included reposition chair -bound residents at least every two hours or more often and implement pressure reducing devices. Also, reduce shear and friction, reduce moisture on the skin, protect the skin, and promote circulation. The following guidelines were to be used for a high-risk resident: a turning and repositioning schedule, wheelchair cushions, and moisture barrier cream. The facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for R26.

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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 reported a census of 45 residents with 12 residents in the sample and ## residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide an environment that remained free from accident hazards for five residents. The facility failed to use the appropriate size full body lift sling for transfers with a mechanical lift for Resident (R)9. The facility failed to follow R26's care plan and left R26 unattended in the bathroom and connected to a mechanical lift, which resulted in a non-injury fall. Additionally, R1 who had lower extremity weakness, the facility failed to apply foot pedals to wheelchair, which resulted in a non-injury fall. These deficient practices could potentially result in an injury. Findings included: - Resident (R) 9 's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and muscle weakness. The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 11, which indicated moderately impaired cognition. R9 required total assistance with activities of daily living (ADLs), which included toileting, transfers, bathing, and wheelchair mobility. R9 required maximal assistance with bed mobility, hygiene, dressing, footwear, and oral care R9 was always incontinent of bladder. The Functional Abilities (Self-Care and Mobility) CAA dated 11/01/24, documented R9 required substantial to dependent care provided by staff. R9 used a full mechanical lift for all transfers. The Admission MDS dated [DATE], documented a BIMS of 14, which indicated intact cognition. R9 was independent with eating, required supervision with oral care, and personal hygiene. She required maximal assist with upper body dressing and required total assistance with bed mobility, transfers, and toileting. The Functional Abilities (Self-Care and Mobility) dated 08/22/24, documented R9 was totally dependent on staff for most ADLs. The resident's Care Plan documented the following: 08/14/24 - Staff instructed R9 required a full body lift sling and mechanical lift for all transfers with assistance of two staff members. The care plan lacked any further direction to staff regarding sling size. The 12/01/24 Weight Summary documented a weight of 154 pounds. During an observation on 12/03/24 at 08:44 PM, Certified Nurse Aide (CNA) S and Certified Medication Aide (CMA) CC assisted R9 to bed from her wheelchair. CNA S and CMA CC utilized the mechanical lift, R9 had a full body mesh sling with a light blue binding around the edge of lift. R9 held onto the bar of the lift, the sling was noted to be quite large, the top of the sling was hanging over R9's head on her face near her eyes and the bottom of the sling was near R9's knees. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/24 at 09:00 AM, CMA CC reported care plans do not state what size or type of sling to use when transferring a resident with a mechanical lift. During an interview on 12/03/24 at 09:00 AM CNA S reported staff would just grab a sling from the linen closet to use if resident did not have one in their room CNA S reported she was not trained to use a sling by size and did confirm the sling covered R9's head to her eyes. During an interview on 12/03/24 at 09:40 AM, Administrative Nurse H reported that she would not care plan the size or what type of sling to use for transfers with a mechanical lift. She reported that the facility did not use weight or height of a resident to determine what sling to sue. Administrative Nurse H reported R9lost weight since admission and that the same sling was being used. She also reported that if staff used a bigger sling the resident would be safer that using a smaller sling. During an interview on 12/04/24 at 08:45 AM, Consultant Staff DD Occupational Therapist reported that therapy would make recommendations for a resident to be a mechanical lift. He also reported the weight rating should be on the lift slings and confirmed that an extra-large Invacare sling for a resident that weighed 154 pounds was too big of a sling. During an interview on 12/04/24 at 10:30 AM, CNA V, CMA L, and CNA M reported the sling that was in the residents' room was the sling they used. They all reported they did not realize the lift slings came in different sizes and the sling had a tag to state what size it was. During an interview on 12/05/24 at 11:14 AM, Administrative Nurse B reported she did not realize the mechanical lift slings were different sizes. Additionally, she did not realize that Invacare had a warning in the manual facility provided to use the only the Invacare slings for the Invacare lifts. She reported that staff would look at the resident's size to determine the appropriate sling to use. Administrative Nurse B confirmed the facility purchased slings from other companies and the sling used for R9 was too large for her. Review of the Invacare Patient Sling Guide dated 04/2007, documented the light blue trimmed sling size was for weighs 200 pounds to 400 pounds. Review of the facility's Invacare Manual undated revealed a warning, slings and accessories designed by other manufactures are not to be utilized as a component of the Invacare lift system. The facility's Safe-Lift dated 10/24 documented the following: Ensure that employees use safe resident handling and movement techniques. Mechanical lift equipment should be used to prevent lifting and handling of residents except when absolutely necessary, such as a medical emergency. Use mechanical lift devices in accordance with instructions and training. The facility failed to use the appropriate size full body lift sling for transfers with a mechanical lift which may have contributed to a pressure ulcer This placed the resident at risk to worsen his current pressure ulcer or develop more skin issue. - Review of the Electronic Health Record (EHR) for Resident (R)1 included diagnoses of generalized (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion), and unsteadiness on feet. The Significant Change Minimum Data Set (MDS) dated 01/24/24, documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The assessment documented that R1 utilized a walker and/or wheelchair for locomotion and documented no falls since the previous assessment. The Falls Care Area Assessment (CAA) dated 01/24/24, documented R1 last fell on [DATE]. The Quarterly MDS dated 10/26/24, documented a BIMS score of 14, which indicated intact cognition. The assessment documented that R1 utilized a walker and/or wheelchair for locomotion and documented one non-injury fall since the previous assessment. The 09/26/24 Care Plan documented R1 was at risk for falls related to gait (manner or style of walking) and balance problems and poor balance and listed the following interventions: On 10/09/15, staff would anticipate and meet the resident's needs. On 10/09/15, staff would ensure that R1's call light was within reach and encourage R1 to use it for assistance and staff would provide prompt response to all requests for assistance. On 10/09/15, the facility would educate resident/family/caregivers about safety reminders and actions to be taken if a fall occurred and the staff would follow the facility's fall protocol. On 01/02/21, following an actual fall, R1 would sit down when applying a facemask. On 12/09/23, following an actual fall, R1 was educated to ensure that the wheelchair was placed at the foot of the bed with wheels locked to provide added stability when standing. Review of the five Fall Risk assessments from 01/24/24 through 10/16/24, revealed R1 was at risk for falls. Review of the Fall Report dated 05/13/24 at 01:12 PM documented the resident put her feet down while being pushed in a wheelchair and staff assisted the resident to the ground, without injury. The report identified the root cause of the fall as lack of foot pedals while staff pushed the resident. The care plan intervention, dated 05/13/24, included staff to offer to place foot pedals on the wheelchair when R1 went out for activities. The Progress Notes dated 05/13/24 at 01:12 PM, documented staff assisted R1 to the floor after she fell out of her wheelchair, on the way to her room. R1 reported to staff that she put her feet down, her feet caught on the carpet underneath the wheelchair, and she fell forward. Staff documented R1 was reeducated to use foot pedals and staff were educated to offer foot pedals on the wheelchair when R1 went out for activities. The resident's care plan documented on 05/13/24 staff would offer foot pedals on the wheelchair when R1 went out for activities. Observation on 12/04/24 at 07:50 AM, revealed R1 self-propelling herself in her wheelchair down the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hallway, the wheelchair lacked foot pedals. On 12/03/24 at 12:22 PM, Certified Medication Aide (CMA) W stated when a resident fell, Certified Nurse Aide (CNA) and/or CMA staff would ensure the resident was safe, then alert other staff that assistance was required, and would notify the nurse. Upon the arrival of the nurse, then staff would follow the instructions of the nurse. On 12/03/24 at 03:00 PM, CNA O stated that when a resident fell, staff would ensure the resident was safe and call for help, which included calling the nurse. Once the nurse arrived, then CNA staff would follow the instructions of the nurse. On 12/03/24 at 03:00 PM, CMA Z and CMA AA stated all residents should have foot pedals on their wheelchair when being assisted by staff. On 09/16/24 at 12:24 PM, Licensed Nurse (LN) N stated the care plan would document if a resident did not require the use of foot pedals on their wheelchair during transport. LN H stated if a resident self-propelled in their wheelchair, became tired and requested assistance, staff should instruct the resident to wait for staff to install the resident's foot pedals the wheelchair before continuing to the resident's room. On 12/03/24 at 03:58 PM, Administrative Nurse B stated that residents with a history of lower extremity weakness should have foot pedals as an option on their wheelchair. Additionally stated that foot pedals are not necessarily required to be on the wheelchair, but if a resident was self-propelling and became weak and requested assistance, staff should ask the resident to wait and retrieve the foot pedals from the room before assisting the resident to their room. Administrative Nurse B confirmed the fall report dated 05/13/24 at 01:12 PM documented that R1 dropped her feet when pushed in the wheelchair (by staff). The facility did not provide a policy related to wheelchair pedals. The facility failed to provide an environment free of accident hazards when on 05/13/24 facility staff pushed R1 in her wheelchair without foot pedals and R1's feet caught on the floor which caused her to experience a fall without injury. This deficient practice had the potential to lead to additional falls with the potential for injury or actual harm. - Review of R26's Electronic Medical Record (EMR) included diagnoses of hypertension (HTN- elevated blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), obesity (excessive body fat), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and polyneuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet). The 01/10/24 Significant Change Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. R26 had behaviors which included delusions, and verbal behavioral symptoms directed towards others t interfered with his care, disrupted the living environment. He rejected care and wandered. R26 used a walker and wheelchair and required partial to moderate assistance with bed mobility and transfers. He required substantial to maximal assistance with toileting hygiene and was dependent on staff with wheelchair mobility. He was frequently incontinent of urine and always incontinent of bowel. The MDS documented two or more (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noninjury falls and one injury fall. Review of the Falls Care Area Assessment (CAA) dated 01/10/24, identified R26 required staff assistance. R26fell three times in two days, which caused injuries due to frequent attempts to self-transfer. He required assistance of two staff with transfers and toileting needs. Review of the Cognitive Loss/Dementia (CAA) dated 01/10/24, identified R26 had a diagnosis of dementia. The 10/8/24 Quarterly MDS documented a staff interview, which indicated the resident had long term and short-term memory problems. He was always incontinent of urine and frequently incontinent of bowel. He was dependent on staff for transfers, toilet hygiene, and mobility. He had one injury fall documented. Review of the resident's Care Plan on 12/02/24 revealed the following interventions: 12/28/21- R26 was at high risk for fall due to being unaware of his safety needs. Interventions at that time to anticipate his needs and have the call light in place. 01/07/24 - Staff would know the resident was not to be left unattended in the bathroom. Staff could stand outside the door with it being ajar for the resident's privacy. 07/26/24 - The facility provided staff education on following resident care plans. Review of the Nurses Notes on 07/26/24 at 07:00 PM document R26 unhooked his sit to stand sling and sat himself on the floor beside the toilet. No injuries were noted. Review of the Fall Packet dated 07/26/24 revealed staff completed a root cause analysis and found that staff needed education on the resident's care plan and the facility provided education as an intervention for the fall. During observation on 12/03/24 at 01:32 PM, CMA BB and CNA X transferred R26 with full body mechanical lift using a sling with yellow around the edge. During an interview on 12/04/24 at 01:15 PM, CMA AA reported staff were aware they could not leave any resident unattended and attached to any lift. During an interview 12/04/24 at 01:15 PM, Licensed Nurse (LN) R reported staff were aware they could not leave any resident unattended and attached to any lift. During an interview on 12/04/24 at 01:22 PM, Administrative Nurse B revealed R26 had a fall after being left on the toilet and attached to the sling with no staff present. Staff returned later to find him on the floor. Administrative Nurse B confirmed staff did not follow the resident's care plan and that additional training was needed. The facility's Safe-Lift policy dated 10/24 documented for staff to use mechanical lift devices in accordance with instructions and training. The facility failed to implement effective fall prevention interventions to prevent falls for (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively impaired R26, who had repeated falls.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. The facility reported a census of 45 residents and identified one centralized medication storage room, four medication carts, and one nurse treatment cart. Based on observations and interviews, the facility failed to provide a safe environment for seven residents, identified as cognitively impaired and independently mobile by the failure to ensure the medication storage room door remained closed and secured when not in use. This deficient practice had the potential to lead to accidental ingestion of prescription and non-prescription medications that could be harmful to the residents. Findings included: - On 12/04/24 at 06:15 AM, the door to the medication room located off of the main lobby was observed to be propped open by a trash can attached to the nurse's treatment cart with no staff present and remained open until 12/04/24 at 06:24 AM when Licensed Nurse (LN) K moved the nurse treatment cart and closed the door. On 12/04/24 at 06:24 AM, LN K stated the medication storage room door should never be propped open and identified the medication storage room contained prescription and non-prescription medications and medical supplies (bandages, dressings, etc.). On 12/04/24 at 12:16 PM, Administrative Nurse B stated she expected staff to ensure the medication storage room door was closed and locked at all times and the medication carts were locked at all times when not in use. Administrative Nurse B confirmed the medication storage room contained surplus prescription and non-prescription medications and assorted medical supplies. Administrative Nurse B stated the door to the medication storage room being propped open was an ongoing and known concern. Administrative Nurse B identified the facility had seven cognitively impaired and independently mobile residents. The facility's Medication Labeling and Storage policy, dated 10/2024, documented the facility would store all medications in locked compartments and only authorized personnel would have access to the keys. The policy documented that compartments containing medications would be locked when not in use and not left unattended if open. The facility failed to provide a safe environment for seven residents by the failure to ensure that the medication storage room door remained closed and secured when not in use. This deficient practice had the potential to lead to accidental ingestion of prescription and non-prescription medications that could be harmful to the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 45 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility. Findings included: - On 12/02/24 at 09:44 AM during an initial tour of the main kitchen, refrigerator and dry food storage areas with Dietary Manager C, the following areas of concern were observed: One container of dry drink mix observed sitting on the floor, unopened. One container of dry potatoes mix observed sitting on the floor, unopened. One bottle of sweet and sour sauce with an expiration date of 09/27/24 found on a shelf. One sealed package of pork loins dated 07/20 and located in the freezer. One sealed package of beef pot roast with a package date of 01/17/23, with ice growing off of it. One unsealed/open bag of chicken wings spread out throughout the freezer, without a date or label. Three sealed bags of unknown meat, without a date or label and located in the freezer. 16 boxes of frozen food items observed sitting on the floor of the walk-in in freezer. On 12/02/24 at 10:31 AM, an interview with Dietary Manager C revealed she expected staff to label, and date opened food items. Dietary Manager C stated that the above concerns identified with dry storage and freezer storage, which included undated and unsealed items were unacceptable. Dietary Manager C confirmed the most recent truck delivery was on 11/29/24. The facility's policy Dating Food and Nourishment dated 06/2024 revealed that any items placed in the refrigerator, perishable items removed from original containers, frozen nourishment and opened pre-dated food items all will be labeled and dated dates on food will be checked daily all foods are to be covered, labeled, and dated. The facility policy Dating Food and Nourishment dated 06/2024 lacked any information about storing boxes on the floor or requiring staff ensure food consumed by ready-to-eat date. The facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to 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
	175521	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wheatlands Health Care Center	750 W Washington St Kingman, KS 67068

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility reported a census of 45 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed transport clean and distribute clean laundry to the residents of the facility when staff failed to perform hand hygiene between resident room contacts. The facility further failed to maintain an effective infection control program related to enhanced barrier precautions (EBP - a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms [MDROs] in nursing homes) when providing catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care for Resident (R) 1, wound care on R9, and peri-care (cleaning of the area between the genitals and anus) for R198. Additionally, the facility failed to provide respiratory care consistent with professional standards of care for R4 regarding the use and storage of oxygen supplies that were not stored in a clean manner or changed when appropriate. These deficient practices had the potential to spread possible infections to the residents in the facility. Findings included: - On 12/03/24 at 08:19 AM, observation of R4's room revealed oxygen tubing that was not in use, was wound in a ball and sat on the top of the oxygen concentrator. The tubing was marked with a date of 11/01/24. Observation on 12/03/24 at 08:53 AM, Licensed Nurse (LN) R performed a dressing change on R9's wound and failed to change gloves or perform hand hygiene between the dirty and clean phases of wound care. Observation on 12/03/24 at 09:31 AM Laundry Aide J was observed going between three resident rooms delivering clean laundry and failed to perform hand hygiene between resident room contacts. Observation on 12/03/24 at 02:03 PM, LN N and Certified Nurse Aide (CNA) I performed a skin check and peri-care for R198. LN N and CNA I failed to perform hand hygiene or change gloves between the dirty and clean phases of peri-care. Additionally, staff failed to place a new and clean brief on R198 after performing peri-care. Observation on 12/04/24 at 07:25 AM, CNA M and Certified Medication Aide (CMA) L performed peri-care and catheter care for R1. CNA M failed to perform hand hygiene or change gloves between the dirty and clean phases of peri-care and catheter care. CMA L failed to perform hand hygiene with the glove change between the dirty and clean phases of catheter care. Additionally, when the catheter bag (a large drainage bag attached to the catheter and hung from the bedrail or wheelchair frame) was changed to a leg-bag (a small drainage bag attached to the catheter and worn on the resident's leg underneath clothing), CMA L failed to place a protective cap on the tip of the tubing and dropped the tip of the catheter bag drainage bag tubing onto the floor. CMA L then placed the catheter bag into a clean trash bag attached to the grab bar in the bathroom without cleaning or replacing the contaminated tubing. Further, CNA M performed peri-care for R1 with multiple swipes and utilized the same wipe. During an interview on 12/03/24 at 09:05 AM, LN R confirmed she did not perform hand hygiene or changed her gloves when she transitioned from the dirty phase to the clean phase of wound care. During an interview on 12/03/24 at 09:34 AM, Laundry Aide J confirmed she did not perform hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hygiene between resident room contacts and stated that she was not trained to perform hand hygiene when only delivering clean laundry. During an interview on 12/03/24 at 09:42 AM Housekeeping Supervisor E stated the expectation was for laundry/housekeeping staff to perform hand hygiene whenever the entered or exited a resident's room. During an interview on 12/04/24 at 07:40 AM, CMA L confirmed she changed her gloves but did not perform hand hygiene when they transitioned from the dirty phase of catheter care and peri-care to the clean phase of catheter and peri-care. Additionally, CNA M confirmed that she did not change her gloves or perform hand hygiene when they transitioned from the dirty phase of catheter care and peri-care to the clean phase of catheter care and peri-care. CMA L confirmed that the catheter tubing fell to the floor but did not believe that the catheter tip had actually came in contact with the ground and continued to place the catheter drainage bag and tubing inside the clean bag attached to the grab bar in the bathroom. CNA M confirmed that she performed peri-care with multiple wipes and utilized the same wipe and stated that she should have used one wipe per swipe. During an interview on 12/04/24 at 08:35 AM, Administrative Nurse G stated the expectation was for staff to place a clean a protective cap on the tip of the catheter drainage bag before it was stored in the bag that was attached to the grab bar in the bathroom. Additionally, Administrative Nurse G stated if the cleanliness integrity of the tip of the catheter drainage bag tubing was in question, staff should discard the drainage system and obtain a new drainage system. She further stated that peri-care should be performed utilizing one wipe per swipe and staff should not fold and re-use disposable wipes and staff should change their gloves and perform hand hygiene between the dirty and clean phases of all cares. During an interview on 12/04/24 at 08:43 AM, CMA Y stated oxygen tubing should be changed every month. During an interview on 12/04/24 at 08:57 AM, Administrative Nurse G stated all laundry/housekeeping staff should perform hand hygiene before and after entering or exiting a resident's room. During an interview on 12/04/24 at 11:19 AM, LN R stated CMA staff should change out the oxygen tubing then date and initial the tubing once a month. During an interview on 12/04/24 at 02:47, Administrative Nurse G stated she was unsure how often oxygen tubing should be changed, but that there was an order in each resident's Electronic Health Record (EHR), which would populate the task on the Medication Administration Record (MAR) The facility's Infection Control policy, dated 12/2023 documented staff would perform hand hygiene before and after contact with a resident, immediately after removing gloves, when moving from contaminated body sites to clean body sites during resident care. The facility failed transport clean and distribute clean laundry to the residents of the facility. Additionally, the facility failed to maintain an effective infection control program related to EBP when providing catheter care for Resident (R) 1 and wound care on R9 and peri-care for R198. Further, the facility failed to provide respiratory care consistent with professional standards of care for R4 regarding the use and storage of oxygen supplies that were not stored in a clean manner or changed when appropriate. These deficient practices had the potential to spread possible infections to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the residents in the facility.