STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175528	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Home	300 S Aztec St Montezuma, KS 67867

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents. The sample included 14 residents reviewed for person-centered care plan development. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan for three residents, Resident (R) 33 related to psychotropic (any class of medications that alter mood or thought) medication use and dementia (a progressive mental disorder characterized by failing memory, confusion) care. R21's care plan lacked interventions related to as needed (PRN) oxygen use and scheduled nebulized (a device which changes liquid medication into a mist easily inhaled into the lungs) medication use. Additionally, R21's care plan lacked a timely intervention related to the care of pressure ulcer/injury (areas of 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). R3's care plan lacked interventions related to the care of pressure ulcer/injury. These deficient practices had the potential to lead to uncommunicated needs which would negatively impact the physical and psychosocial well-being of the residents. Findings Included: - R21's Electronic Health Record (EHR) revealed diagnoses of asthma (a disorder of narrowed airways that caused wheezing and shortness of breath). The Significant Change Minimum Data Set (MDS) dated 01/18/24, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R21 was not at risk for pressure ulcer/injury and received oxygen. The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 10/15/24 documented R21 required extensive assistance with mobility in and out of his recliner, was able to reposition self but had no skin issues or pressure injuries. The Quarterly MDS, dated 12/05/24 documented a BIMS score of 15, which indicated intact cognition. The assessment documented R21 did not have pressure ulcer/injury, was not at risk for pressure ulcer/injury but had a pressure relieving device on his chair and did not receive oxygen. Review of the Care Plan updated 12/12/24, on 01/15/25 revealed an intervention dated 12/20/24 that documented R21 had an open sore on the right buttock (first documented on 10/25/24) and instructed staff to provide frequent repositioning. Review of the Care Plan updated 12/12/24, on 01/15/25 lacked interventions related to oxygen or nebulized medication use or care/maintenance of oxygen or nebulizer equipment. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Orders revealed the following orders: Monitor and measure open area on right buttock, every day shift, every Tuesday for open area, initiated on 10/29/24 at 07:00 AM and discontinued on 01/11/25. Oxygen via nasal cannula at two liters per minute (2LPM) PRN for respiratory distress, initiated on 08/16/24 at 02:02 PM. Albuterol Sulfate (a short-acting medication to open the lower airways of the lungs) 2.5 milligrams (mg)/three milliliters (mL) 0.083 percent (%) inhale one vial via nebulizer every four hours as needed for wheezing or shortness of breath related to asthma, initiated on 02/21/23 at 02:15 PM. Ipratropium-Albuterol (a long-acting medication to open the lower airways of the lungs) 0.5-2.5 (3) mg/three mL, inhale one vial via nebulizer two times a day related to asthma, initiated on 10/14/24 at 08:00 PM. Review of the electronic Medication Administration Record (eMAR) from 11/01/24 to 01/15/25 revealed R21 received appropriate doses of the nebulized medications. The eMAR lacked documentation of PRN oxygen or PRN albuterol. The eMAR documented appropriate changing of oxygen and nebulizer equipment. Review of Progress Notes revealed the following: On 10/25/24 at 03:18 AM, R21 had two open areas on his right buttock near the intergluteal cleft and that R21 removed pillows staff had placed behind his back to offload pressure. On 12/20/24 at 04:02 AM, R21 had an open sore on his right buttock and R21 had pressure-relieving cushions on his recliner and electric scooter. On 01/11/25 at 02:22 PM, R21 had an open area on his right buttock that had been evaluated as healed on 01/08/25. During an observation on 01/14/25 at 09:56 AM, R21 rested in his recliner with legs elevated, pressure relieving pad in recliner and wheelchair. Oxygen concentrator observed in R21's room with oxygen cannula coiled under the concentrator handle and nebulizer equipment observed on a table in R21's room. During an observation on 01/15/24 at 07:00 AM, R21 was seated in his wheelchair with pressure reliving pad in recliner and wheelchair. Oxygen concentrator observed in R21's room with oxygen cannula coiled under the concentrator handle and nebulizer equipment observed on a table in R21's room. During an observation on 01/16/25 at 10:20 AM or R21's room revealed an oxygen concentrator in R21's room with oxygen cannula coiled under the concentrator handle and nebulizer equipment observed on a table in R21's room. During an interview on 01/16/25 at 10:28 AM, Certified Nurse Aide (CNA) P revealed if a skin issue was discovered during cares that the nurse would be notified immediately so they could assess the area. CNA P revealed all cares delivered to the residents should be found on the care plan in the care plan book at the nurses' station or in the EHR. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 10:33 AM, CNA U revealed if any skin abnormalities were discovered during cares that the nurse would be notified so they could assess and treat the area. CNA U revealed that staff carry a pocket [NAME] slip that has each resident's cares listed During an interview on 10/16/25 at 10:48 AM, Licensed Nurse (LN) X revealed if a new skin abnormality is discovered staff would notify the nurse who would fill out a wound report and initiate orders to monitor and describe the wounds and would also trigger a note on the report sheet that is shared between shifts. LN X revealed that care plan interventions and updates are developed by Administrative Nurse B, Administrative Nurse C, Administrative Nurse D and/or Administrative Nurse E During an interview on 01/16/25 at 09:33 AM, Administrative Nurse D revealed that all LN staff are responsible to develop or modify care plan interventions as the situations are discovered or change. Administrative Nurse D stated that if a resident has new physician orders, the nurse that noted the orders should add that care and intervention to the care plan. Additionally, Administrative Nurse D stated that if a nurse discovered a new wound or pressure ulcer/injury that the nurse should develop a new care plan intervention as soon as possible. During an interview on 01/16/25 at 10:58 AM, Administrative Nurse B stated the expectation if a change with a resident that the nurse on duty would develop and/or update the care plan with new interventions and to discuss the changes with Administrative Nurse D or Administrative Nurse E to verify appropriateness of the interventions. Administrative Nurse B further revealed the nurses who noted new orders would update the care plan, but she was unsure if the staff were aware of this expectation. Administrative Nurse B further confirmed the care plan lacked oxygen and nebulized medication interventions. Administrative Nurse B confirmed the care plan intervention dated 12/20/24 was for the wound first documented in the EHR on 10/25/24 and stated that the intervention was not addressed in the care plan in a timely manner and failed to meet the expectation for care plan development. The facility's Comprehensive Person-Centered Care Plans policy, dated 08/15/19 documented each resident would receive nursing care based on individual needs and the care plan was a personalized daily plan that indicated what nursing care is needed, how it was to be accomplished and included resident's preferences. The care plan would be available to each person assigned to a resident and would be reviewed and revised as needed. The care plan could be delegated by the Director of Nursing (DON - Administrative Nurse B) to others but the DON would continue to supervise the process and was involved with evaluation and revision of all care plans. Additionally, the nurse on duty would develop a temporary care plan when new problems developed and included (but not limited to) new medications, skin care and falls. The policy documented that the care plan would be revised to include interventions for pressure ulcer/injury with changes in physician's treatment. Further, the policy documented that all physician's orders, notes and consultant notes would be reviewed and appropriately added to the care plan. The facility failed to develop and implement a person-centered comprehensive care plan for related to PRN oxygen use and scheduled nebulized medication use. Additionally, R21's care plan lacked a timely intervention related to the care of pressure ulcer/injury. This deficient practice had the potential to lead to uncommunicated needs which had the potential to negatively affect the physical and psychosocial well-being of R21. - R3's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), history of venous thrombus and embolism (an obstruction in a blood vessel due to a blood clot or other (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	foreign matter that gets stuck while traveling through the blood stream) and acquired absence of left leg below the knee. The Annual Minimum Data Set (MDS) dated 07/04/24, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R3 was not at risk for pressure ulcer/injury. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/04/24 documented R3 required assistance with bathing related to left leg amputation. The Quarterly MDS, dated 10/03/24 documented a BIMS score of 15, which indicated intact cognition. The assessment documented R3 was not at risk for pressure ulcer/injury. Review of the Care Plan updated 01/09/25, on 01/15/25 lacked documentation related to a wound on the left leg stump. The Physician Orders revealed: Silverlon Island Dressing (a type of dressing intended for use up to seven days) , ensure it is intact and do not remove every evening and night shift for wound care, dated 12/27/24 at 03:00 PM. Review of the EHR revealed the following: On 12/02/24 at 04:08 PM, R3 reported an open area on his left leg stump and this was communicated with the physician. On 12/11/24 at 01:30 PM, R3's wound was evaluated by the physician and new orders were written. On 12/23/24 at 10:10 AM, R3 was evaluated by the physician and new orders were written for R3 to be evaluated by an off-site wound care clinic. During an observation on 01/14/25 at 09:00 AM, R3 sat on the edge of his bed with dressing in place on left leg stump. During an observation on 01/14/25 at 11:24 AM, R3 rested in his recliner. During an observation on 01/15/25 at 04:00 PM, R3 rested in his recliner. During an interview on 01/14/25 at 11:24 AM, R3 revealed that he had a wound on the stump of his left leg from something inside his prosthetic limb and was being treated at an off-site wound clinic. During an interview on 01/15/25 at 04:00 PM, R3 revealed that the wound clinic staff had discovered a protrusion on the plastic liner in his prosthetic limb and that wound clinic staff had corrected the protrusion and that he no longer feels the pressure on the wound that was present before. During an interview on 01/16/25 at 10:28 AM, Certified Nurse Aide (CNA) P revealed if a skin issue was discovered during cares that the nurse would be notified immediately so they could assess the area. CNA P revealed all cares delivered to the residents should be found on the care plan in the care plan book at the nurses' station or in the EHR. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 10:33 AM, CNA U revealed if any skin abnormalities were discovered during cares that the nurse would be notified so they could assess and treat the area. CNA U revealed that staff carry a pocket [NAME] slip that has each resident's cares listed During an interview on 10/16/25 at 10:48 AM, Licensed Nurse (LN) X revealed if a new skin abnormality is discovered staff would notify the nurse who would fill out a wound report and initiate orders to monitor and describe the wounds and would also trigger a note on the report sheet that is shared between shifts. LN X revealed that care plan interventions and updates are developed by Administrative Nurse B, Administrative Nurse C, Administrative Nurse D and/or Administrative Nurse E During an interview on 01/16/25 at 09:33 AM, Administrative Nurse D revealed that all LN staff are responsible to develop or modify care plan interventions as the situations are discovered or change. Administrative Nurse D stated that if a resident has new physician orders, the nurse that noted the orders should add that care and intervention to the care plan. Additionally, Administrative Nurse D stated that if a nurse discovered a new wound or pressure ulcer/injury that the nurse should develop a new care plan intervention as soon as possible. During an interview on 01/16/25 at 10:58 AM, Administrative Nurse B stated the expectation if a change with a resident that the nurse on duty would develop and/or update the care plan with new interventions and to discuss the changes with Administrative Nurse D or Administrative Nurse E to verify appropriateness of the interventions. Administrative Nurse B further revealed the nurses who noted new orders would update the care plan, but she was unsure if the staff were aware of this expectation. Administrative Nurse B further confirmed the care plan lacked interventions related to wound care and failed to meet the expectation for care plan development. The facility's Comprehensive Person-Centered Care Plans policy, dated 08/15/19 documented each resident would receive nursing care based on individual needs and the care plan was a personalized daily plan that indicated what nursing care is needed, how it was to be accomplished and included resident's preferences. The care plan would be available to each person assigned to a resident and would be reviewed and revised as needed. The care plan could be delegated by the Director of Nursing (DON - Administrative Nurse B) to others but the DON would continue to supervise the process and was involved with evaluation and revision of all care plans. Additionally, the nurse on duty would develop a temporary care plan when new problems developed and included (but not limited to) new medications, skin care and falls. The policy documented that the care plan would be revised to include interventions for pressure ulcer/injury with changes in physician's treatment. Further, the policy documented that all physician's orders, notes and consultant notes would be reviewed and appropriately added to the care plan. The facility failed to develop and implement a person-centered comprehensive care plan for related to wound care. This deficient practice had the potential to lead to uncommunicated needs which had the potential to negatively affect the physical and psychosocial well-being of R3.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 had a census of 50 residents and the sample included 14 residents. Based on observation, record review, and interview, the facility failed to revise the fall care plan with an appropriate intervention for two residents. Resident (R) R33 and R36. Additionally, the facility failed to update care plan with facility acquired pressure ulcer (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) for R2, and R23's care plan was not updated with psychotropic (alters mood or thought) medications changes. These deficient practices had the potential to have a negative effect on the overall physical and psychosocial well-being of the residents in the facility. Findings included: - During the onsite survey, the surveyors identified a concern regarding the revision of care plans for four of the sampled residents. R36's Electronic Health Record (EHR) revealed the care plan lacked fall intervention. The fall that occurred on 12/12/24 had no intervention placed to prevent further falls. R33's EHR revealed the care plan lacked fall interventions. The falls that occurred on 01/16/24, 06/06/24, 06/15/24, 07/07/24, and 10/23/24. R2's EHR revealed the care plan lacked a revision for an open area noted on the right buttock that was facility acquired on 05/22/24. R23's EHR revealed the care plan lacked revisions to reflect the changes in psychotropic medication as follows: R23's Buspirone HCl tablet (is used to treat certain anxiety disorders or to relieve the symptoms of anxiety) 15 milligrams, give one tablet by mouth, two times a day related to anxiety disorder, ordered on 3/28/2023 was not on R23's care plan in EHR or noted on the paper update care plan sheet in care plan book. During an interview on 01/16/25 at 08:40 AM, CMA K reported if a care plan had changed recently, the nurse would update the staff during report at beginning of the shift. CMA K also reported she would look at the care plan in the book or on the computer to check for any change of care. During an interview on 01/16/25 at 10:30 AM, Administrative Nurse B expected care plans to be correct and revised, she verified that R23's care plan did not have Buspirone or anxiety concern on care plan. During an interview on 01/16/25 at 10:45 AM, Administrative Nurse E reported the nurse on duty would update the care plan sheet in the care plan book. During an interview on 01/16/25 at 10:48 AM, Licensed Nurse (LN) X reported that the care plan update sheet in care plan book is updated. Administrative Nurse B, Administrative Nurse D or Administrative Nurse E would update the care plan in the EHR. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/25 at 10:58 AM, Administrative Nurse B stated the expectation if a change with a resident that the nurse on duty would develop and/or update the care plan with new interventions and to discuss the changes with Administrative Nurse D or Administrative Nurse E to verify appropriateness of the interventions. Administrative Nurse B further revealed the nurses who noted new orders would update the care plan, but she was unsure if the staff were aware of this expectation. The facility's Comprehensive Person-Centered Care Plans policy dated 08/15/19 documented each resident would receive nursing care based on individual needs and the care plan was a personalized daily plan that indicated what nursing care is needed, how it was to be accomplished and included resident's preferences. The care plan would be available to each person assigned to a resident and would be reviewed and revised as needed. The care plan could be delegated by the Director of Nursing (DON - Administrative Nurse B) to others but the DON would continue to supervise the process and was involved with evaluation and revision of all care plans. Additionally, the nurse on duty would develop a temporary care plan when new problems developed and included (but not limited to) new medications, skin care and falls. The policy documented that the care plan would be revised to include interventions for pressure ulcer/injury with changes in physician's treatment. Further, the policy documented that all physician's orders, notes and consultant notes would be reviewed and appropriately added to the care plan. The facility failed to revise four residents' care plans after pressure ulcer injuries occurred for R2. The facility failed to revise the care plan for R23 regarding psychotropic medication changes. The facility failed to revise the care plan after falls occurred for R33 and R36.

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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 50 residents with 14 residents sampled, which included 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 perform an ongoing assessment of a stage three (full thickness pressure injury extending through the skin into the tissue below) facility acquired pressure ulcer for Resident (R) 2. Findings included: - R2'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 quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord). The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R2 required maximal to total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, and bathing. R2 had a colostomy and urostomy. No pressure ulcers or skin impairments. Preventative mattress and cushion in place. The Pressure Ulcer CAA dated 05/08/24, documented CAA triggered secondary to level of assistance required with ADLs while in bed, R2 had a history of pressure ulcers, but currently does not have any skin breakdown. The Quarterly MDS dated 10/31/24, documented a BIMS of 15. R2 required total assistance of staff with ADLs. R2 required set-up for eating and oral care. R2 had a facility acquired stage three pressure ulcer. The 01/14/25 Care Plan documented interventions which included: On 05/23/22, staff were instructed to reposition and turn R2 every two hours and as needed. R2 had personal air mattress applied to bed and personal cushion applied to wheelchair. Staff educated to encourage R2 to change position every two hours, alternate periods of rest with activity out of bed in order to prevent pressure ulcers. Staff instructed to educate R2 the causative factors and measures to prevent skin injury. R2 was non-complaint with preventative measures. Staff were instructed to provide good nutrition and hydration. Staff were instructed to monitor, document location, size, treatment of skin injury. The Physicians Orders dated 01/14/25 documented: Arginaid Oral Packet (Nutritional Supplements) give 1 packet orally, one time a day, for supplement date ordered, 09/27/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change outer dressing use alginate (a wound dressing made from seaweed that absorbs fluid and forms a gel to help wounds heal) and put a foam border dressing over. Do not remove the membrane wrap. If contact layer and steri-strips (adhesive wound closures) do not stay in place, try to keep skin substitute on wound bed and replace secondary dressing, date ordered 10-04-24. Measure and describe wound weekly on Friday for open area on right buttock, date ordered 11/17/24. Apply skin barrier ointment (A&D ointment or calmoseptine or Vaseline {an over-the-counter ointment that protects and heals skin irritations}) to peri wound (skin surrounding the wound) and cover with gauze, date ordered 12-16-24. Review of the Progress Notes from 05/22/24 to 01/14/25 documented the following: The 05/22/24 at 08:30 AM Progress Note revealed R2 assessed with a new open area on right buttock. Measured 1.7 centimeter (cm) with a 0.7 cm by 0.8 cm open are. Physician notified and new order received. The 05/31/24 at 05:20 PM Progress Note revealed open area on right buttock had worsened, Physician notified, and new orders were received. The 05/31/24 at 10:01 PM Skin/Wound Note revealed right buttock measured 6cm by 4 cm, the peri wound had skin peeling, some bleeding noted from open area. Review of the EHR, Wound Clinic notes, and wound book notes from 05/31/24 to 06/25/24, 09/03/24 to 09/17/24 and beyond 11/22/24 lacked documentation of ongoing weekly assessments as per physician orders for R2's stage three pressure ulcer. Review of Wound Clinic Notes 07/01/24 thru 01/13/25 monthly visits. On 07/01/24 no measurements noted. On 07/29/24 no measurements noted. On 08/26/24 right buttock measured 2.3 cm by 0.7 cm by 0.3 cm stage three pressure ulcer. On 09/25/24 no measurements. On 10/23/24 right buttock measured 1.5 cm by 0.4 cm by 0.4 cm. On 11/19/24 right buttock measured 1 cm by 0.3 cm by 0.6 cm On 12/16/24 right buttock measured 0.1 cm by 0.1 cm by 0.1 cm. During an interview on 01/14/25 at 09:32 AM, R2 reported she acquired the pressure ulcer at the facility about six months ago. She reported she thought it was from an allergic reaction but was not sure. During an observation on 01/15/25 at 07:19 AM, observed a pinpoint open area of right inner buttock during dressing change. Noted a scant amount of yellow drainage on old dressing when removed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Redness surrounding the peri wound noted. During an interview on 01/15/24 at 07:34 AM, Licensed Nurse (LN) H reported the charge nurse would measure and document on any skin condition weekly. LN H reported that R2 would have her skin notes completed on Friday's. During an interview on 01/15/25 at 07:50 AM, R2 reported that staff do encourage her to reposition every two hours, and not stay up for long periods. However, R2 reported she would choose to reposition when she wanted to as she liked to keep busy. During an interview on 01/16/25 at 10:48 AM, LN X reported any new skin concern, the staff would notify the nurse. The nurse would complete a wound report, update the physician and would put an order in EHR to monitor and describe skin concern. During an interview on 01/16/25 at 11:15 AM, Administrative Nurse B reported that Administrative Nurse C was the wound nurse for the facility. Administrative Nurse B expected pressure ulcers to be monitored weekly. The facility's policy Skin Protocol - Staging and Care dated 11/19/24 documented residents with high risk for skin breakdown required a pressure reducing device for chair and mattress. Lotion to pressure areas and moisture barrier. For stage three pressure injury assess location, size, including width, length, depth, and tunnelling, if any, drainage, granulation (a normal part of the wound healing process, where new tissue and blood vessels form in the wound bed) at each dressing change and document in record on wound documentation form. Document all findings in resident's chart. The facility failed to perform an ongoing assessment of a stage facility acquired pressure ulcer for R2.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility had a census of 50 residents and the sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from accident hazards for four residents. Resident (R) 37 who had medications located in her room that was not secured. Additionally, three residents R21, R33, and R36 had repeated falls with inappropriate or lacked a care plan revision after falls. These failures placed the affected residents at risk for preventable accidents and related injuries. Findings included: - During the onsite survey, the surveyors identified a concern regarding the unsecured medications observed in one resident's room during interview. Additionally, three residents noted to have repeated falls, when care plans were reviewed, falls that had occurred either lacked an intervention, or an appropriate intervention was completed. During an observation on 01/14/25 at 01:36 PM, R37 had three over the counter medications on her over the bed table. A jar of Amish Origins Deep Penetrating Pain Relief Cream (used for arthritis, sore muscles, and joints), a tube of Hydrocortisone one percent cream (used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions), and a bottle of Anti-Itch cream lotion (used on the skin) to help relieve pain and itching from minor burns, cuts, scrapes, insect bites, and rashes). All three medications had a warning label Keep out of reach of children. During an interview on 01/15/25 at 05:10 PM, R37 reported she always kept her medications on her over the bed table and had never been educated to secure medications in her room. During an interview on 01/15/25 at 05:15 PM, Certified Medication Aide (CMA) M reported that residents should have medications that are allowed to be in their room in a drawer. CMA M reported she did not believe that residents had a place in their room to lock and secure medications. During an interview on 01/16/25 at 10:18 AM, License Nurse (LN) J reported she was not aware of an assessment for self-medication she had to complete on the electronic health record (EHR). LN J reported the physician would order may keep at bedside and self-administer medications. LN J reported that there was no area in a resident's room to secure medications. During an interview on 01/16/25 at 11:01 AM, Administrative Nurse E reported the EHR had a self-administration assessment that the nurse should complete when a resident has an order to self-medicate and may keep at bedside and verified that R37 did not have an assessment completed. Additionally, Administrative Nurse E reported that medications in a resident's room should be in a drawer. During review of R36's EHR, noted that R36 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition dated 10/25/24, had several falls noted. The Progress Note on 03/14/24 at 08:30 AM, staff found R36 on the floor, seated upright by bed. R36 reported she lost her balance and fell. R36 had a small laceration by her left eye, and a skin tear noted on left elbow. The Progress Note on 05/21/24 at 08:20 AM, R36 had a witnessed fall in the bathroom after she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stepped on her toe and lost her balance, staff attempted to prevent fall. R36 had minor injuries noted, bruise on left knee, left wrist, and third finger of left hand. The Progress Note on 12/12/24 at 06:45 AM, staff found R36 on the floor in bathroom next to the toilet. R36 reported her foot gave out and she fell. No injuries noted. During review of the Care Plan the falls that occurred on 03/14/24 and 05/21/24 had no immediate intervention to prevent further falls. The intervention used after fall was reviewed was an order for Physical and Occupational therapy. The fall that occurred on 12/12/24 had no intervention placed to prevent further falls. During review of R21's EHR, noted that R21 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition dated 12/05/24, had falls noted. The Progress Note on 07/24/24 at 09:11 PM, R21 was found on floor in his room, noted that he had three head injuries and injured left shoulder. R21 was transferred to the hospital. The Root Cause Analysis unknown date revealed, impaired mobility related to dizziness, that was related to diuretic use. No immediate intervention noted. The Care Plan intervention was PT/OT evaluation, dated 07/24/24. The Progress Note on 11/11/24 at 06:30 PM, R21 was found on his knees on the floor, with his upper body in the wheelchair seat. R21 reported his feet tangled under him and cased his to fall. Noted a bruise on left hand, left knee had an abrasion and right ear had a small cut noted. The Root Cause Analysis unknown date revealed R21 had overestimated his ability and did not use call light for assistance. No immediate intervention noted. The Care Plan intervention was PT evaluation, dated 11/11/24. During review of R33's EHR, noted that R33 had a BIMS score of three, which indicated severely impaired cognition dated 01/02/25, R33 had several falls noted. The Progress Note on 01/16/24 at 04:03 PM, Witnessed fall by staff, R33 hit his shoulder on the wall in hallway and fell backwards. Noted a bruise on left wrist. No fall intervention noted on care plan. The Progress Note on 04/11/24 at 11:50 AM, R33 reported he fell backwards when he had reached into his closet to pick something up. No injuries noted. R33 was reminded to ask staff for assistance on the Care Plan dated 04/11/24. R33 had a BIMS of eight dated on 02/01/24. The Progress Note on 05/30/24 at 10:45 AM, R33 was found on the floor in his room next to wheelchair. R33 reported he had to fix the wheelchair. The Care Plan intervention dated 05/03/24, maintenance to check brakes. The Progress Note on 06/06/24 at 01:52 PM, R33 was found on the floor in his room next to the recliner, no injuries noted. No intervention noted on the care plan. The Progress Note on 06/09/24 at 01:30 PM, R33 was found on the floor in his room next to recliner. No injuries noted. The Care Plan update sheet dated 06/09/24 revealed fall bed/chair alarm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This intervention was noted on the Care Plan already dated 05/26/23. The Progress Note on 06/15/24 at 10:45 AM, R33 was found on the floor near his room-mates bed. R33 reported he attempted to close the door to the room and lost his balance. The Care Plan intervention dated 06/15/24, continue plan of care. The Progress Note on 07/07/24 at 08:00 AM, R33 was found on the floor near his bed, bed alarm had alerted staff. No injuries noted. The Care Plan intervention dated 07/07/24, continue plan of care. The Progress Note on 10/23/24 at 08:28 PM, R33 was found on floor on his left knee in front of his wheelchair. R33 reported he did not know how he fell. Intervention is to not put R33 in his recliner after supper. The Care Plan intervention dated 10/23/24, maintenance to check chair alarm. The intervention noted in the Progress note was not on he care plan. During an interview on 01/16/25 at 08:40 AM, CMA K reported if a care plan had changed recently, the nurse would update the staff during report at beginning of the shift. CMA K also reported she would look at the care plan in the book or on the computer to check for any change of care. During an interview on 01/16/25 at 10:28 AM, Certified Nurse Aide (CNA) P reported if a resident is found on the floor, the staff call the nurse on the walkie talkie, the nurse would investigate, the team would discuss an intervention, then reported to incoming shift. During an interview on 01/16/25 at 10:45 AM, Administrative Nurse E reported the staff would discuss after the fall/incident and develop an intervention. The nurse on duty would update the care plan. Administrative Nurse E reported that during a care plan meeting the incidents would be looked at that time for the intervention completed. During an interview on 01/16/25 at 10:48 AM, Licensed Nurse (LN) X reported the staff are notified on duty of the new intervention after a fall, and it is communicated in shift report. The Administrative Nurse B, Administrative Nurse D or Administrative Nurse E would update the care plan. During an interview on 01/16/25 at 10:58 AM, Administrative Nurse B reported that Administrative Nurse D and or Administrative Nurse E are expected to check the intervention for appropriateness. CNAs would suggest interventions and the nurse on duty is expected to update the care plan. The facility's policy Self-Administration of Medications dated 01/13/2020 documented each resident who wishes to self-administer medications may do so if the interdisciplinary team has determined that self-administration is clinically appropriate. The nurse would complete the Medication Self-Administration assessment in EHR and reviewed quarterly. The facility lacked a policy of storage of medications in a resident's room. The facility's policy Falls and Prevention dated 01/17/2017 documented all staff from all departments are part of the Fall Prevention Program and are to be stewards to fall safety. Every fall will be investigated and discussed with all available staff on the scene, using a root cause approach. One new intervention will be put in place. The facility failed to ensure a safe environment free from accident hazards for R21, R33, R36, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37. This placed the resident at risk for injury and preventable accidents.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents. The sample included 14 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure Resident (R)46's as needed (PRN) psychotropic (any class of medications that alters mood or thought) medication had the required 14 day stop date or clinical rationale for continued use beyond the initial 14 days. This deficient practice had the potential to lead to the resident receiving unnecessary psychotropic medications. Findings Included: - R46's Electronic Health Record (EHR) revealed diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), and hypertension (elevated blood pressure). The admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident received antianxiety (a class of medications that calm and relax people) and diuretic (medication to promote the formation and excretion of urine) medication during the look back period. The Psychotropic Drug Use CAA dated 03/26/24 documented R46 had adverse consequences of prescribed antianxiety medication that had been exhibited such as: sedation, decline in cognitive abilities, slurred speech, short-term memory loss, drowsiness, or little to no activity involvement. The Physician Orders revealed a telephone order for Xanax (Alprazolam, a benzodiazepine class of medication which works on the neurotransmitters in the brain and is used to treat anxiety) 0.25 milligram (mg), give 0.25 mg every six hours PRN for anxiety, dated 06/22/24. The order lacked a stop date or rationale for the continued use of the medication. Review of the electronic Medication Administration Record (eMAR) revealed R46 received doses of the PRN Xanax (alprazolam) on 06/22/24 and 09/16/24 and lacked evidence of an ordered stop date. During an observation on 01/15/25 at 09:34 AM, R46 sat in her wheelchair, working on a puzzle in her room and appeared relaxed and calm. During an interview on 10/23/24 at 11:22 AM, Administrative Nurse B confirmed the order for PRN Xanax (alprazolam) in R46's EHR had indefinite marked for the end date. Administrative Nurse B revealed she was unaware of the regulatory requirement that PRN psychotropic medications required a 14 day stop date or documented an appropriate clinical rationale for continued use beyond the 14 days. The facility's Psychotropic Medications policy dated 11/14/17 documented that PRN orders for anti-psychotic (psychoactive or psychotherapeutic) drugs are limited to 14 days and will not renew unless the attending physician evaluates the resident for the appropriateness of the ordered medication. The facility failed to ensure a 14-day stop date or physician evaluation for continued use beyond the 14 days, for R46's PRN psychotropic medication, Xanax. This deficient practice had the potential (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for R46 to receive an unnecessary psychotropic medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility reported a census of 50 residents. Based on observations, interviews, and record review, staff failed to complete proper hand hygiend during wound care for Resident (R)2 and R21, to ensure best practice regarding infection control and prevention. Findings included: - Observation on 01/15/25 at 07:00 AM, Licensed Nurse (LN) J removed a dressing from a skin tear on R21's without hand hygiene, cleaned the wound with normal saline (NS- saline water solution for medical use) and gauze, did not change her gloves or perform hand hygiene, placed new border foam dressing, then transitioned to morning Activities of Daily Living (ADL) assistance with glove change only, no hand hygiene. Observation on 01/15/25 at 07:03 AM, R2 was assisted back into bed by Certified Nursing Assistant (CNA) O and CNA N. CNA O assisted R2 with dressing then removed gloves, put on new gloves but did not wash her hands, then applied Foley tubing to R2's leg. Observation on 01/15/25 at 07:19 AM, LN H and CNA N entered a resident's room and applied PPE with no concerns. LN H cleansed wound to right buttock, removed another 4x4 from package with her dirty glove to dry the area, then removed gloves. LN H did not wash her hands, applied gloves and applied calcium alginate (highly absorbent dressing) to the center of the wound, then applied a dressing. LN H then applied A&D ointment to the area around the wound and removed her gloves. LN H put the remaining calcium alginate in the packet and back into the box, and cleaned up the area. During an interview on 01/15/25 at 07:08 AM, LN J confirmed she did not perform appropriate glove changes. She stated she should have changed her gloves and performed hand hygiene between dirty and clean phases. During an interview on 01/15/25 at 07:34 AM, LN H acknowledged that she should have washed her hands when she removed her gloves before she applied new gloves. She was aware that every time a person removes gloves their hands should be washed. During an interview on 01/15/25 at 07:43 AM, CNA O verified that she did not wash her hands when she had removed her gloves and applied new gloves and continued cares. CNA O reported she should have washed her hands prior to applying new gloves. During an interview on 01/16/25 at 08:15 AM, Administrative Nurse C revealed she routinely educated staff on infection control and expected them to follow infection control practices including hand washing and wound. During an interview on 01/16/25 at 10:30 AM, Administrative Nurse B revealed she expected staff to follow good infection control procedures. The facility failed to ensure staff followed appropriate hand hygiene during wound care for R2 and R21. These deficient practices had the potential to spread possible infections to the residents in the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. The facility reported a census of 50 residents. Based on interview and record review the facility failed to ensure an effective and ongoing antibiotic stewardship for appropriate antibiotic use for the residents of the facility to prevent antibiotic resistance and the spread of multi-drug resistant organisms Findings included: - During an interview on 01/16/24 at 08:15 AM, Administrative Nurse C reported she is the Infection Preventionist (IP- a trained healthcare professional who works to prevent the spread of infections in healthcare facilities) for the facility. Administrative Nurse C revealed she tracked when an antibiotic started, she reported the nurses on the units were to follow McGeer's Criteria (a set of guidelines for identifying infections in long-term care facilities) and notify her when a new antibiotic was started. Administrative Nurse C reported this did not happen. Administrative Nurse C reported she was not notified that R30 was being tested for clostridium difficile (C-diff: contagious bacteria characterized by foul smelling frequent loose bowel movements) on 01/13/24 and revealed that is a problem. She said it is the policy that precautions should have been started. She reported that she had not heard of any signs or symptoms of C-diff, but the surveyor informed her that the EHR documented 56 loose stools out of 75 in the past 30 days. The surveyor also informed Administrative Nurse C that she had another antibiotic scheduled to start on that day. She agreed that it needed to be investigated. Surveyor and Administrative Nurse C looked at previously ordered antibiotics for R30: Cephalexin Oral Capsule 500 MG (Cephalexin) one capsule by mouth two times a day for UTI until 08/29/2024 ordered on 08/22/24. It did not have the culture and sensitivity completed and it was not on the tracking form. Levaquin Oral Tablet 250 MG (Levofloxacin) one tablet by mouth one time a day for UTI for seven days ordered on 12/23/2024 was not on the tracking record. Azithromycin Oral Tablet 250 MG (Azithromycin) four tablets by mouth one time only for bacterial pneumonia and UTI ordered on 1/5/2025 was not on the surveillance tracking record and was an unusual dose that she agreed should have been investigated at that time. Amoxicillin-Pot Clavulanate Oral Tablet 500-125 MG (Amoxicillin & Pot Clavulanate) one tablet by mouth two times a day for bacterial pneumonia for seven days ordered on 1/5/2025 was not on the tracking record. Administrative Nurse C confirmed that there was not a culture and sensitivity for R12 for Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) one tablet by mouth two times a day for Bacteriuria for seven days order on 11/28/2024. Administrative Nurse C confirmed R12 had an order for Cefdinir Oral Capsule 300 MG (Cefdinir) one capsule by mouth two times a day for cough for 10 Days started on 1/7/2025 lacked an appropriate diagnosis for an antibiotic and it was not on the tracking form. During an interview on 01/16/25 at 10:30 AM, Administrative Nurse B revealed that she was not aware that R30 had loose stools, and that communication was a problem. Administrative Nurse B confirmed the lack of completion of the computerized infection monitoring system. She reported the infection control nurse was working to improve the infection control surveillance and antibiotic stewardship issues with communication and documentation. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Antibiotic Stewardship policy, reviewed 05/01/24, instructed staff to monitor antibiotic use with support from teh Medical Director, Pharmacist, and Director of Nursing/designee. Staff were to monitor antibiotic use and infections. All practitioners would be encouraged to follow standard of practice for ordering antibiotic treatment for symptoms including but not limited to McGeer Criteria. The facility failed to ensure an effective and ongoing antibiotic stewardship for appropriate antibiotic use for the residents of the facility to prevent antibiotic resistance and the spread of multi-drug resistant organisms.