STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Kansas City	8900 Parallel Parkway Kansas City, KS 66112

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 66 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R)39 foot pedals for her wheelchair. This deficient practice left R39 vulnerable to possible injury due to unmet care needs. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dysarthria (weak speech), pacemaker(and artificial device to stimulate the heart muscle), transient ischemic attack (a temporary blockage of blood flow to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), difficulty in walking, cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affect right dominant side, depression (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented R39 had an impairment to one side. The MDS documented R39 was dependent on staff to put on and take off footwear. R39's Cognitive Loss Care Area Assessment (CAA) dated 10/18/23 documented R39 shows alterations in cognition related to a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion), cognitive-communication deficit, and a history of CVA and was evident by memory impairments and intermittent delusions. R39's Care Plan dated 01/18/23 documented R39 was at risk for impaired cognitive function or impaired thought processes related to the diagnosis of dementia. Staff were to orient R39 to the facility's surroundings, time, and location as needed. Staff to explain care and procedures as needed. The plan of care dated 08/03/23 documented R39 had a contracture (abnormal fixation of a joint or muscle) of her right upper and lower extremity. On 07/09/24 at 07:36 AM R39 rolled herself to breakfast using her left hand. Certified Medication Aide (CNA) R asked R39 if she wanted to be pushed to breakfast and said R39 should raise her legs. R39 lifted her legs. R39 was not wearing her foot/ankle brace and was wearing her white tennis shoes. R39's right foot hit the floor twice while CNA R propelled the wheelchair. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 11:05 PM in an interview, Certified Nurse's Aide (CNA) M stated pedals should be provided if staff were going to push R39 and said R39 would have made it to the breakfast table alone. On 07/10/24 at 11:15 PM in an interview, Licensed Nurse (LN) G stated R39 should have pedals on her wheelchair if staff were pushing her to ensure she doesn't get hurt when her feet touch the ground. On 07/10/24 at 04:20 PM in an interview, Administrative Nurse D said if staff were pushing a resident in the wheelchair, staff should provide wheelchair pedals. The facility's Accommodation of Needs policy revised on 08/23 the facility was to assure that a resident has the right to resident and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. The facility failed to provide R39 with wheelchair pedals for her wheelchair when staff were pushing her wheelchair. This deficient practice left R39 vulnerable to possible injury due to unmet care needs.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. The facility identified a census of 66 residents. The sample included 19 residents with two residents reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure that residents were free from resident-to-resident abuse when Resident (R) 31 threw hot coffee on R40. This placed R40 and other residents on the west hall at risk of possible harm and or injury and impaired quality of life. Findings included: - The electronic medical record (EMR) for R31 documented diagnoses of hemiplegia and hemiparesis (muscular weakness and paralysis of one side of the body), diabetes mellitus (DM- -when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Annual Minimum Data Set (MDS) dated 10/07/23 for R31 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R31 had impairment to one side of his upper extremities and impairment to both lower extremities. R31 required the use of a motorized wheelchair for mobility. R31 was independent of his functional abilities. R31 received antidepressant (a class of medications used to treat mood disorders), hypnotic (a class of medications used to induce sleep), and opioid (a broad group of pain-relieving medicines that work with your brain cells) medications. The Functional Abilities Care Area Assessment (CAA) dated 10/12/23 for R31 documented R31 had DM and staff monitors and administers his insulins (a hormone that lowers the level of glucose in the blood) as ordered. R31 remained at the facility with no plans to discharge at this time. R31 remained fairly independent and asked for assistance as needed. R31 worked with occupational and physical therapy. R31 had a bilateral lower extremity amputation (surgical removal of a body part) and had right-sided hemiparesis/hemiplegia. R31 is transferred with a slide board and has a trapeze (a bar used to assist the patient with a means of self-help to change position, to move from the bed, or to transfer to and from a wheelchair) on his bed to help with bed mobility. R31 used an electric wheelchair for locomotion. R31's Care Plan last updated 04/30/24 documented R31 was independent with locomotion of his power wheelchair. The staff was directed to approach the resident in a calm manner. Staff was to intervene as necessary to protect the rights and safety of others. Staff was directed to approach/speak in a calm manner. Staff was directed to divert attention, remove the resident from the situation, and take the resident to an alternate location as needed. Staff was directed that R31 would get upset easily if he felt that other residents impeded on his prayer group time. Staff was to remind R31 that the facility commons area was for everyone, and other residents had the same right to use the space. Staff was to redirect R31 to his room if he became verbally aggressive. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Facility Investigation report dated 07/05/24 documented an incident involving R31 and R40. The Investigation Summary documented that on 07/05/24 Administrative Staff A was notified by Administrative Nurse D that nursing staff had reported that R31 had spilled coffee on R40 at approximately 08:00 AM. The summary documented a witness statement from an unnamed staff member noted R31 had a disagreement with another resident, R40, based on the sitting area in the dining room. R31 became upset when R40 would not move from a certain spot. R31 began to yell at R40 to move. R31 grabbed a cup of coffee and threw it onto R40, hitting his abdomen and thighs. R31 stated he had accidentally spilled his coffee. As R31 wheeled his motorized wheelchair back to his room he stated that he would throw the coffee in his face. Licensed Nurse (LN) G immediately assessed R40, noting that the bottom of his shirt and the top of his pants were wet. R40 denied any pain or injury. LN G assessed R40's abdomen, and no redness or blistering was noticed. R40 was instructed to report if the area became worse or had noted pain to report it to the nurse. R40's provider was notified, and no further orders were given; the family was notified. After breakfast Administrative Nurse D went and spoke to R31 and he explained to her that the incident was an accident. A Late Entry Nursing Progress Note for R31 dated 07/06/24 at 06:52 AM by LN G, documented: at approximately 08:30 AM yesterday (07/05/24) R31 had a disagreement with another resident based on a sitting area in the dining room. R31 became upset when another resident did not move from a certain spot. R31 began to yell for the other resident to move, and R31 grabbed a cup of coffee and threw it on the other resident, hitting his abdomen and thighs. R31 then casually stated, Oops I accidentally spilled my coffee. As R31 was wheeling back to his room, he stated that he would throw it in his face. A Nursing Note dated 07/05/24 at 04:44 PM for R40 documented tiny, raised areas noted on his left inner thigh from where the coffee had hit him. R40 continued to deny any pain or discomfort. On 07/09/24 at 09:09 AM R31 sat in his wheelchair in his room and stated the incident on 07/05/24 with R40 was an accident and he did not want to talk anymore about it. On 07/09/24 at 11:42 AM R40 sat in his wheelchair in his room watching TV. R40 stated he had let that incident go; it was just something that happened. On 07/10/24 at 09:20 AM LN G stated that she had been at the nurse's desk at the time of the incident on 07/05/24 and did not see what transpired between R31 and R40 but did hear the two Certified Nurse Aides (CNA) talking about the incident. The two CNAs separated the residents. LN G stated she took R40 to his room to assess him and R31 wheeled himself back to his room. LN G stated that R31 typically did not come out of his room in the morning for breakfast and was not sure what caused the incident to happen. LN G stated the incident was reported immediately to Administrative Nurse D. LN G stated that no further action was taken at that time for R31. LN G stated when she assessed R40's thigh the next day there were noted scabs to the skin, but she had not ever noted any blisters in the area. On 07/10/24 at 03:25 PM, Administrative Nurse D stated she was at the facility when the incident occurred between R31 and R40 and she had talked with R31 in his room after the incident and R31 had said that it was an accident. Administrative Nurse D stated no further action was taken with R31 at the time as he spent most of his time in his room and she did not feel that he would be a threat to any other residents. Administrative Nurse D stated she did notify Administrative Staff A immediately of the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/25 at 03:36 PM Administrative Staff A stated that all residents should be free from abuse from another resident and the facility did have policies regarding abuse and did go over abuse frequently with staff. Administrative Staff A stated that interventions should have been put in place to ensure no further harm would occur. The facility Abuse: Prevention of and Prohibition Against last revised 01/10/23 documented that it was the policy of this facility that each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility would provide oversight and monitoring to ensure that its staff delivered care and services in a way that promoted and respected the rights of the residents to be free from abuse, neglect, and misappropriation of resident property, and exploitation. The facility would take action to protect and prevent abuse and neglect from occurring by supervising staff to identify and correct any inappropriate or unprofessional behaviors. Establish a safe environment; identify, correct, and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation are likely to occur. Assuring that structures and processes were in place to keep residents from abuse and neglect. Identifying, assessing, care-planning for appropriate interventions, and monitoring residents with needs and behaviors that might lead to conflict or neglect. The facility would take steps to protect all residents from physical and psychosocial harm during and after the investigation. The facility failed to ensure residents were free from abuse when R31 threw hot coffee on R40. This placed the residents at risk of possible harm and or injuries and impaired quality of life.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. The facility identified a census of 66 residents. The sample included 19 residents with two residents reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure a resident-to-resident altercation was fully investigated and interventions implemented to prevent further abuse after R31 threw hot coffee on R40. This placed the residents on the west hall at risk of possible harm and or injury and impaired quality of life. Findings included: - The electronic medical record (EMR) for R31 documented diagnoses of hemiplegia and hemiparesis (muscular weakness and paralysis of one side of the body), diabetes mellitus (DM- -when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Annual Minimum Data Set (MDS) dated 10/07/23 for R31 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R31 had impairment to one side of his upper extremities and impairment to both lower extremities. R31 required the use of a motorized wheelchair for mobility. R31 was independent of his functional abilities. R31 received antidepressant (a class of medications used to treat mood disorders), hypnotic (a class of medications used to induce sleep), and opioid (a broad group of pain-relieving medicines that work with your brain cells) medications. The Functional Abilities Care Area Assessment (CAA) dated 10/12/23 for R31 documented R31 had DM and staff monitors and administers his insulins (a hormone that lowers the level of glucose in the blood) as ordered. R31 remained at the facility with no plans to discharge at this time. R31 remained fairly independent and asked for assistance as needed. R31 worked with occupational and physical therapy. R31 had a bilateral lower extremity amputation (surgical removal of a body part) and had right-sided hemiparesis/hemiplegia. R31 is transferred with a slide board and has a trapeze (a bar used to assist the patient with a means of self-help to change position, to move from the bed, or to transfer to and from a wheelchair) on his bed to help with bed mobility. R31 used an electric wheelchair for locomotion. R31's Care Plan last updated 04/30/24 documented R31 was independent with locomotion of his power wheelchair. The staff was directed to approach the resident in a calm manner. Staff was to intervene as necessary to protect the rights and safety of others. Staff was directed to approach/speak in a calm manner. Staff was directed to divert attention, remove the resident from the situation, and take the resident to an alternate location as needed. Staff was directed that R31 would get upset easily if he felt that other residents impeded on his prayer group time. Staff was to remind R31 that the facility commons area was for everyone, and other residents had the same right to use the space. Staff was to redirect R31 to his room if he became verbally aggressive. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Facility Investigation report dated 07/05/24 documented an incident involving R31 and R40. The Investigation Summary documented that on 07/05/24 Administrative Staff A was notified by Administrative Nurse D that nursing staff had reported that R31 had spilled coffee on R40 at approximately 08:00 AM. The summary documented a witness statement from an unnamed staff member noted R31 had a disagreement with another resident, R40, based on the sitting area in the dining room. R31 became upset when R40 would not move from a certain spot. R31 began to yell at R40 to move. R31 grabbed a cup of coffee and threw it onto R40, hitting his abdomen and thighs. R31 stated he had accidentally spilled his coffee. As R31 wheeled his motorized wheelchair back to his room he stated that he would throw the coffee in his face. Licensed Nurse (LN) G immediately assessed R40, noting that the bottom of his shirt and the top of his pants were wet. R40 denied any pain or injury. LN G assessed R40's abdomen, and no redness or blistering was noticed. R40 was instructed to report if the area became worse or had noted pain to report it to the nurse. R40's provider was notified, and no further orders were given; the family was notified. After breakfast Administrative Nurse D went and spoke to R31 and he explained to her that the incident was an accident. A Late Entry Nursing Progress Note for R31 dated 07/06/24 at 06:52 AM by LN G, documented: at approximately 08:30 AM yesterday (07/05/24) R31 had a disagreement with another resident based on a sitting area in the dining room. R31 became upset when another resident did not move from a certain spot. R31 began to yell for the other resident to move, and R31 grabbed a cup of coffee and threw it on the other resident, hitting his abdomen and thighs. R31 then casually stated, Oops I accidentally spilled my coffee. As R31 was wheeling back to his room, he stated that he would throw it in his face. A Nursing Note dated 07/05/24 at 04:44 PM for R40 documented tiny, raised areas noted on his left inner thigh from where the coffee had hit him. R40 continued to deny any pain or discomfort. On 07/09/24 at 09:09 AM R31 sat in his wheelchair in his room and stated the incident on 07/05/24 with R40 was an accident and he did not want to talk anymore about it. On 07/09/24 at 11:42 AM R40 sat in his wheelchair in his room watching TV. R40 stated he had let that incident go; it was just something that happened. On 07/10/24 at 09:20 AM LN G stated that she had been at the nurse's desk at the time of the incident on 07/05/24 and did not see what transpired between R31 and R40 but did hear the two Certified Nurse Aides (CNA) talking about the incident. The two CNAs separated the residents. LN G stated she took R40 to his room to assess him and R31 wheeled himself back to his room. LN G stated that R31 typically did not come out of his room in the morning for breakfast and was not sure what caused the incident to happen. LN G stated the incident was reported immediately to Administrative Nurse D. LN G stated that no further action was taken at that time for R31. LN G stated when she assessed R40's thigh the next day there were noted scabs to the skin, but she had not ever noted any blisters in the area. On 07/10/24 at 03:25 PM, Administrative Nurse D stated she was at the facility when the incident occurred between R31 and R40 and she had talked with R31 in his room after the incident and R31 had said that it was an accident. Administrative Nurse D stated no further action was taken with R31 at the time as he spent most of his time in his room and she did not feel that he would be a threat to any other residents. Administrative Nurse D stated she did notify Administrative Staff A immediately of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/25 at 03:36 PM Administrative Staff A stated that all residents should be free from abuse from another resident and the facility did have policies regarding abuse and did go over abuse frequently with staff. Administrative Staff A stated that interventions should have been put in place to ensure no further harm would occur. The facility Abuse: Prevention of and Prohibition Against last revised 01/10/23 documented that it was the policy of this facility that each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility would provide oversight and monitoring to ensure that its staff delivered care and services in a way that promoted and respected the rights of the residents to be free from abuse, neglect, and misappropriation of resident property, and exploitation. The facility would take action to protect and prevent abuse and neglect from occurring by supervising staff to identify and correct any inappropriate or unprofessional behaviors. Establish a safe environment; identify, correct, and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation are likely to occur. Assuring that structures and processes were in place to keep residents from abuse and neglect. Identifying, assessing, care-planning for appropriate interventions, and monitoring residents with needs and behaviors that might lead to conflict or neglect. The facility would take steps to protect all residents from physical and psychosocial harm during and after the investigation. The facility failed to ensure a resident-to-resident incident was fully investigated and appropriate interventions put in place to ensure residents were free from abuse. This placed the residents at risk of possible harm and or injuries.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. The facility identified a census of 66 residents. The sample included 19 residents. Based on observation, record review and interview the facility failed to ensure staff obtained physician-ordered labs for Resident (R) 45 and the facility failed to notify the physician of the delay in R45's labs being obtained. This placed R45 at risk of delayed care and related complications. Findings included: - The electronic medical record (EMR) for R45 documented diagnoses of hypertension (HTN- elevated blood pressure), urinary tract infection (UTI-an infection in any part of the urinary system), and compression fracture (occurs when one or more bones in the spine weaken and crumple) of the lumbar vertebra. R45's admission Minimum Data Set (MDS) dated 06/12/24 documented that R45 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R45 required partial/moderate assistance from staff for functional abilities. R45 was dependent on staff for toileting and bathing. R45 was frequently incontinent of the bladder and occasionally incontinent of bowel. R45 had not been on a trial toileting program. R45 was taking an antibiotic (medication used to treat infections). R45's Urinary Care Area Assessment (CAA) dated 06/17/24 documented R45 was at the facility for a skilled stay after a hospitalization for a fall with a fracture to the lumbar spine. R45 had an alteration in functional abilities and requires assistance from staff. R45 was at risk for alteration in nutrition. R45 tolerated his current diet without difficulty. R45 needed set-up assistance to eat. R45's weight had been stable. R45 will continue to monitor weights and labs as ordered and report to the physician as needed. R45's Care Plan directed staff to monitor and document for signs and symptoms of a UTI. Staff was to monitor, document, and report to the physician as needed signs and symptoms of dehydration. Staff was directed to obtain and monitor lab and diagnostic work as ordered. Staff was directed to report results to the physician and follow up as indicated. A Nursing note dated 07/05/24 at 06:20 PM under the Progress Notes tab of the EMR documented R45 presented with an altered mental status and was diaphoretic (sweating heavily). An order was received for immediate (STAT) labs for urinalysis (UA-lab analysis of urine), complete metabolic panel (CMP-laboratory blood test), and complete blood count (CBC- laboratory blood test) with differential. Straight catheterization (a process involving a tube inserted directly into the urethra, to drain urine) was completed for the UA. A thick off-white sediment-like discharge was noted in R45's brief and the sample in the urine cup was very thick and off-white. The lab order was placed online, and a message was left with the lab company to notify them of the STAT labs and request a return phone call. A Nursing note dated 07/07/24 at 07:21 AM documented that staff called the lab on 07/07/24 at 09:00 AM for a STAT lab draw for R45. The lab company was called again requesting a STAT lab draw. A message was left, and the orders were changed in the lab system to STAT. A Nursing note dated 07/07/24 at 08:42 PM for R45 documented that R45 had not voided during that shift. Straight catheterization was completed at this time with 800 milliliters of urine output. A new sample was collected for a UA and was placed in the lab fridge for pick-up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Lab Results Report dated 07/08/24 at 05:42 PM documented a UA that was ordered and collected on 07/05/24 at 05:30 PM. The report was reviewed by staff on 07/09/24 at 08:42 AM. The report indicated abnormal results. A Lab Results Report dated 07/08/24 at 02:53 PM for a CBC with differential and a CMP. The report indicated abnormal results for R45's white blood count (WBC- measures the number of white cells in your blood, a high level indicates an increase in cells in the blood that fight infections). R45 had an Orders Note dated 07/09/24 at 12:47 PM that documented an order for ertapenem sodium injection (an antibiotic medication used to treat severe UTIs) one gram intramuscularly once daily for UTI. The provider was notified of a possible allergy. R45's EMR and Progress Notes lacked documentation of further monitoring of her condition and signs and symptoms from 07/05/24 to 07/09/24. On 07/09/24 at 11:41 AM R45 sat in her wheelchair in her room. R45 appeared to be talking to herself in words that were unable to be understood and moving her hands and arms about in the air. On 07/10/24 at 11:15 AM R45 still laid in her bed. R45 had not gotten up to eat breakfast. On 07/10/24 at 01:35 PM Licensed Nurse (LN) H stated the nurse should be making observations and documenting any noted changes to a resident's status if there had been noted changes. LN H stated he did not work on Friday 07/05/24 or the weekend so he could not say what took place with R45, but it appeared that R45 had not been followed up on with the nurse and the STAT lab was not obtained as it should have been. LN H stated he would have notified Administrative Nurse D that the lab had not been obtained as well as notifying the physician. On 07/10/24 at 03:25 PM Administrative Nurse D stated that a lack of communication had occurred with staff and there had been a delay in R45 getting her STAT labs obtained. Administrative Nurse D stated that the facility did not have a backup lab that was used if the regular lab had not picked up or come to the facility to draw labs. Administrative Nurse D stated she had not been made aware that R45's STAT labs had not been obtained as ordered and was not aware that the physician had not been notified of the delay either. Administrative Nurse D stated the facility would be looking for an alternate lab company to ensure this situation did not occur again. Administrative Nurse D stated that R45 should have been followed up on by staff over the weekend and her condition was documented in the nurse's notes. The facility did not provide a policy regarding quality of care. The facility failed to ensure R45 received the appropriate care and services when staff failed to ensure that STAT physician lab orders were obtained when ordered. This deficient practice caused a delay in R45's care and treatment for a UTI and placed her at risk for further complications.

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	175548	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Kansas City	8900 Parallel Parkway Kansas City, KS 66112

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 66 residents. The sample included 19 residents with two residents reviewed for position and mobility. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 39's leg/ankle brace was applied to her right leg when she was out of bed to prevent her contractures (abnormal permanent fixation of a joint or muscle) from worsening. This deficient practice left R39 at risk for further decline and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). or mobility. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dysarthria (weak speech), pacemaker(and artificial device to stimulate the heart muscle), transient ischemic attack (a temporary blockage of blood flow to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), difficulty in walking, cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affect right dominant side, depression (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented R39 was dependent on staff putting on and taking off footwear. R39's Functional Abilities Care Area Assessment (CAA) dated 10/18/23 documented R39 had an alteration in her self-care functional abilities related to DM and CVA with right-sided hemiparesis, R39 required total assistance with her activities of daily living (ADLs). R39's Care Plan revised 10/25/23 documented that R39 had an alteration in self-care related to a diagnosis of right-side hemiplegia following a CVA. The plan of care documented R39 requires assistance with functional abilities. The plan of care dated 08/03/23 documented R39 had a contracture of her right upper and lower extremity. R39 's EMR under the Orders tab dated 05/10/23 revealed the following physician order: staff to apply a right leg brace on the foot/ ankle when R39 is out of her bed every shift. A review of R39's clinical record documented no refusals of staff applying a brace to her right leg. On 07/09/24 at 07:33 AM R39 sat in her room in her wheelchair, R39 had her white tennis shoes on and no leg or ankle brace. R39 stated the Certified Nursing Aide (CNA) did not know how to put on the leg brace. R39 stated her leg brace shoe was black. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 11:04 AM Certified Nurse's Aide (CNA) O stated R39's brace should have been placed on her leg; she stated the brace helps R39 control her leg. On 07/10/24 at 01:40 PM Licensed Nurse (LN) H stated the brace should be applied while R39 was out of her bed if she did not refuse to have staff apply the brace. LN H stated that R39 did have contractures. On 07/10/24 at 03:25 PM Administrative Nurse D stated R39's brace should be applied. She stated a lot of times, the residents refused the services. Administrative Nurse D stated the refusals should be documented, and the nurse on duty should follow up with the resident to ensure the brace was placed properly. The facility's Contracture Documentation policy documented that residents who enter the facility without a limited range of motion, shall not experience a reduction in range of motion unless the residents' clinical conditions demonstrate that a reduction in range of motion is unavoidable. The facility's policy documents that a resident with a limited range of motion or contracture shall receive appropriate treatment and services, based on the comprehensive assessment of the resident, to increase the range of motion and or to prevent further decrease. The facility failed to apply R39's leg/ankle brace to her right leg when she was out of bed. This placed the resident at risk for worsening of contractures and decreased mobility.

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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 66 residents. The sample included 19 residents with five reviewed for accidents. Based on observation, record review and interview the facility failed to ensure a safe environment free from potential hazards out of reach of the five cognitively impaired, independently mobile residents. The facility additionally failed to follow the fall prevention interventions care planned for Residents (R)29 and R58. The facility additionally failed to ensure R6's room was free from physical hazards. These deficient practices placed the residents at risk for preventable accidents and injuries. Findings Included: -On 07/08/24 at 07:09 AM an inspection of the main lobby's kitchenette next to the receptionist revealed an accessible kitchenette entrance with a cleaning chemical bottle and Microkill wipes. All the cleaning products identified contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. A pressurized carbon dioxide (CO2 - pressurized gas) sat unsecured in a cabinet under the sink. On 07/08/24 at 07:11 AM an inspection of the west hall revealed an unlocked oxygen storage room. The room contained four large pressurized canisters and two small pressurized canisters left in the room. On 07/08/24 at 07:19 AM an inspection of the west dining hall revealed a large leak in front of the drink station covered with soiled wet towels on the floor. The area had no Wet Floor sign in place for the leaking on the floor. On 07/08/24 at 08:00 AM an inspection of R53's room revealed an unsecured pressurized supplemental oxygen cannister sat directly on the floor next to his wheelchair. At 08:05 AM an unidentified staff member entered the room and stated That's not supposed to be left here and removed the canister. On 07/08/24 at 09:00 AM Administrator A stated the facility was currently having the kitchenette remodeled and the towels were on the floor due to a leak. On 07/11/24 at 02:55 PM Administrative Nurse D stated the oxygen tanks and oxygen rooms should be secured in a locked room and placed on a rack. She stated the tanks should never be left free-standing in resident areas. She stated cleaning chemicals should be locked in the utility closets or storage area. She stated they should never be left out accessible to the residents. The facility's Chemical Storage policy revised 02/2024 indicated the facility will ensure safe storage of chemicals that may be hazardous to the residents. The policy indicated cleaning supplies will be stored and kept in locked storage closets and supervised when in use. The facility failed to ensure a safe environment free from potential hazards out of reach of the five cognitively impaired, independently mobile residents. These deficient practices placed the residents at risk for preventable accidents and injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Medical Diagnosis section within R29's Electronic Medical Records (EMR) included diagnoses of dementia, cognitive communication deficit, insomnia (difficulty sleeping), and dysphagia (difficulty swallowing). R29's Significant Change Minimum Data Set (MDS) completed 04/25/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated no behaviors. The MDS indicated she required substantial to maximal assistance with bed mobility, bathing, dressing, toileting, and personal hygiene. The MDS indicated she required set-up assistance with her meals. The MDS indicated she weighed 251 pounds (lbs.). The MDS indicated she was at risk for skin breakdown and utilized pressure-reducing devices in her bed and wheelchair. R29's Falls Care Area Assessment (CAA) completed 04/30/24 indicated she was at risk for falls related to her medical diagnoses and impaired cognitive function. R29's Functional Abilities CAA completed 04/03/24 indicated she required staff assistance with all her activities of daily living (ADLs). The CAA indicated a care plan will be completed to reduce the risks related to her falls, skin care, incontinence, and nutrition. R29's Care Plan initiated 07/01/22 indicated she was at risk for alterations in her functional abilities related to her medical diagnoses. The plan indicated she was dependent on staff for transfers, bed mobility, dressing, toileting, bathing, and personal hygiene. The plan indicated she was at risk for falls. The plan indicated her low air-loss mattress was to be discontinued on 06/17/24 as a result of a non-injury fall. The plan indicated she had non-slip floor strips, proper bed height, and a Dycem (non-slip mat to prevent sliding) mat under her wheelchair cushion. A Fall Committee report dated 06/17/24 indicated R29 was found on the floor on 06/14/24 by therapy staff. The report indicated R29 was impulsive and wanted to get to breakfast. The report indicated her low air-loss mattress was supposed to be discontinued to reduce her fall risks. On 07/10/24 at 09:34 AM an inspection of R29's room revealed her bed in the lowest position. R29's call light was attached to her bed within reach. Non-skid strips were placed on the floor next to her bed. R29's bed had a Drive Model low air-loss mattress with a pump in place at the foot of her bed. The pump was active and set to 350 pounds (lbs.) and firm. On 07/10/24 at 09:44 AM Licensed Nurse (LN) G verified the low air-loss mattress and pump were in place and set to 350 lbs. She stated the pumps were usually set to the resident's current body weight but was unable to find an order or verify if R29 was supposed to have the mattress. She stated staff were expected to check the bed and settings each shift. On 07/10/24 at 02:55 PM Administrative Nurse stated staff were expected to check the function and orders for the low air-loss mattresses and bed canes to ensure they were safely applied. She stated that R29's low air-loss mattress should not be in place if it was reported to be unsafe for her. The facility's Fall Management System policy revised 12/2023 indicated the facility would ensure a safe environment was maintained free from potential accidents and hazards. The policy noted residents with high-risk factors will be provided with individualized care interventions to reduce the risks of injury or falls. The policy indicated the implemented interventions will be accessible to facility staff and followed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure R29's fall interventions were followed related to her low air-loss mattress. This deficient practice placed the residents at risk for preventable accidents and injuries. -The Medical Diagnosis section within R58's Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (high blood pressure), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), unsteadiness on feet, and need for assistance with personal cares. R58's admission Minimum Data Set (MDS) completed 05/17/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated has was dependent on staff assistance for ambulation, transfers, bathing, toileting, and bed mobility. The MDS indicated he had a history of falls but none since admission. R58's Falls Care Area Assessment (CAA) completed 05/27/24 indicated he was at risk for falls related to his medical diagnoses. The CAA noted he had an alteration in his functional abilities and required staff assistance. The CAA noted he received physical, occupational, and speech therapy assistance. R58's Care Plan initiated 05/11/24 indicated he had an alteration in functional abilities. The plan noted he was dependent on staff for all activities of daily living. The plan noted he was dependent on two staff for assistance with sit-to-standing, toileting transfers, bathing transfers, and chair-to-bed transfers (05/11/24). R58's plan indicated he was a fall risk. The plan indicated he had a non-injury fall on 06/14/24 due to increased weakness with transfers. The intervention indicated he required two-person assistance for transfers (06/17/24). R58's EMR under Progress Note indicated that R58 fell while being transferred into a shower chair by a staff member. The note indicated he slid while being transferred and the staff member lowered him to the floor. The note indicated the involved staff member and R58's family member witnessed the fall. On 07/08/24 at 10:11 AM R58 lay in his bed. R58's bed was in the highest position but he reported he preferred it to be higher. R58 reported he had one slip at the facility but did not have any injuries. He stated he was being assisted by a staff member and slipped. He stated she helped him to the floor. On 07/10/24 at 02:15 PM, Certified Nurse Aide (CNA) M stated R58 required two staff for assistance due to him being weak. She stated the level of care and number of staff required for transfers was listed in the care plans. She stated all staff had access to the care plans. On 07/10/24 at 02:55 PM Administrative Nurse D stated staff were expected to review the care plan and ensure they followed the interventions list. She stated all staff had access to the plans and could verify with nursing staff if in question. She stated the care plan was updated to reflect all falls that occurred, and interventions would have been added to ensure no future falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Management System policy revised 12/2023 indicated the facility would ensure a safe environment was maintained free from potential accidents and hazards. The policy noted residents with high-risk factors will be provided with individualized care interventions to reduce the risks of injury or falls. The policy indicated the implemented interventions will be accessible to facility staff and followed. The facility failed to ensure the safe transfer of R58 during his shower care. The deficient practice placed R58 at risk for preventable falls and injuries. - R6's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypotension (low blood pressure), end-stage renal disease (ESRD-a terminal disease of the kidneys), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), hypertension (HTN-elevated blood pressure), muscle weakness, repeated falls, cognitive communication deficit, difficulty in walking, unsteadiness on his feet, and dysphagia (swallowing difficulty). The Annual Minimum Data Set (MDS) for R6 dated 06/12/24 recorded a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R6 was severely impaired with no vision or seeing only light colors or shapes. The MDS documented R6s eyes do not appear to follow objects. The MDS documented during the observation period that R6 did not require oxygen during the observation period. R6's Functional Abilities CAA dated 06/12/24 documented R6 was a long-term resident due to being legally blind, R6 was able to see shadows. The CAA documented R6 had an alteration in functional abilities and requires assistance from staff. The CAA documented R6 was at an increased risk of decline due to his need for assistance with activities of daily living (ADLs). The CAA documented nursing would continue to assist with ADLs to reduce decline. R6's Care Plan dated 07/03/23 documented R6 was at risk for impaired cognitive function. Staff were to identify themselves at each interaction. The plan of care documented that staff were to face R6 when speaking and to make eye contact. The plan of care documented that nursing staff were to reduce any distractions; staff should turn off the TV, and radio, and close the door. On 07/08/24 at 09:08 AM R6 laid flat in his bed on his back awake. R6 stated he had not been on oxygen; he stated the oxygen canister had been in his room for a while, and he stated he was unsure of the time frame. R6 stated one of the Certified Nurse's Aides (CNA) had put the canister there, and went on to say the oxygen storage room was next to his room. R6 stated the CNA placed the oxygen canister against his wall, instead of putting the oxygen canister away in the storage room. The oxygen canister was not in a holder or secured. The oxygen canister read 200 PSI (a unit of pressure expressed in pounds of force per square inch of area). On 07/09/24 at 08:01 AM R6 lay in his bed, head of the bed elevated. R6 had his head covered up with his blanket. R6 stated nursing staff had come into his room and removed the oxygen tank. On 07/10/24 at 09:27 AM CNA M stated, the process was to keep all oxygen tanks in a stroller or locked in the oxygen room. She stated oxygen tanks should not be left in a resident's room unsecured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/10/24 at 09:28 AM Licensed Nurse (LN) F stated the oxygen room was always locked and oxygen canisters should be placed in a holder, never left on the floor unsecured. On 07/10/24 at 03:05 PM Administrative Nurse D stated all oxygen tanks should be secured. She stated all oxygen tanks not in use should be in the locked oxygen room. The facility's Oxygen Handling and Storage policy revised on 01/24 documented the facility was to provide proper use and handling of oxygen tanks in the facility. The storage of oxygen tanks must be accompanied in a safe manner. All oxygen tanks must be secured to a wall within a chain or heavy cable. The policy documented no tank would be left unattended on a transport dolly; transport dollies would be used as a support when oxygen was being administered to a resided. The facility failed to ensure a safe environment free from accident hazards when staff left an oxygen canister unsecured and free-standing in R6's room. This deficient practice placed R6 at risk for injuries.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 66 residents. The sample included 19 residents with two residents observed for bowel and bladder. Based on observation, record reviews, and interviews the facility failed to ensure the standard of care was provided for Resident (R)39, who had a history of urinary tract infection (UTI-an infection in any part of the urinary system). This deficient practice placed R39 at risk of complications and further UTIs. Finding included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dysarthria (weak speech), pacemaker(and artificial device to stimulate the heart muscle), transient ischemic attack (a temporary blockage of blood flow to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), difficulty in walking, cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affect right dominant side, depression (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented that R39 was dependent on staff for all toileting hygiene. R39's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/18/23 documented R39 was frequently incontinent of bowel and bladder, and staff would assist as needed with toileting and peri care. R39's Care Plan dated 10/31/23 documented R39 had bowel and bladder incontinence. Nursing should monitor and document for signs and symptoms of UTIs, pain, temperature, urinary frequency, and foul-smelling urine The plan of care dated 10/25/23 documented that nursing staff was to administer prophylactic antibiotics as ordered for recurrent UTIs; nursing to observe for adverse effects and report to physician as needed. R39's EMR under the Orders tab revealed the following physician orders: Cranberry tablets give 1 tab 400 milligrams(mg) two times a day for UTI prevention, dated 08/21/23 Cefdinir (antibiotic) give 300 (mg) capsules, nursing to administer one capsule by mouth two times a day for seven days for a UTI, dated 07/07/24 On 07/10/24 at 07:10 AM R39 sat in her wheelchair in her doorway. R39 stated she was waiting for the nursing staff to come and toilet her. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 07:26 AM R39 was standing, holding onto the handrail in the bathroom. Certified Nurse's Aide (CNA) O laid the peri wipes package in R39's wheelchair and took several out and laid the wipes on the wheelchair seat. CNA O donned gloves and wiped R39's bottom. R39 had a bowel movement. CNA O then wiped R39's front peri area, doffed her gloves, and donned a second pair of gloves without performing hand hygiene. CNA O then wiped R39's front peri area, doffed her gloves, and pulled R39's brief and pants up without performing hand hygiene first. CNA O helped R39 into her wheelchair, flushed the toilet, picked up the trash bag, and then used hand sanitizer when leaving R39's room. CNA O stated she should have performed hand hygiene before donning gloves and should have washed her hands when she was finished with toileting R39. CNA O stated the facility had not done education since she started on hand hygiene. On 07/10/24 at 07:18 AM, Licensed Nurse (LN) G stated the CNA should have doffed her gloves and washed her hands when going from back or dirty to front or clean, and always wash hands with soap and water after toileting a resident. LN G stated poor hand hygiene could make residents more vulnerable to UTIs. On 07/10/24 at PM, Administrative Nurse D stated staff should perform hand hygiene, don gloves, wash the back side, doff gloves, perform hand hygiene, doff gloves, wash the front side, doff gloves, and perform hand hygiene. Administrative Nurse D stated staff have not had a follow-up in-service or training, the training the staff received was check-offs when they were hired. The facility's Female Perineal and Catheter Care procedure documented, consistent perineal care promotes good hygiene, reduces skin irritation and breakdown and allows for greater personal comfort. The facility failed to ensure the standard of care was provided during peri care for R39. This deficient practice placed R39 at risk of further UTIs.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. The facility identified a census of 66 residents. The sample included 19 residents with six reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to monitor weights consistently in order to identify loss and immediately involve the registered dietician and physician to evaluate if nutritional needs were met for Resident (R) 27's enteral nutrition regimen (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew or swallow food) to prevent a significant, unplanned weight loss of 11.74 percent (%) within two months. Findings Included: - The Medical Diagnosis section within R27's Electronic Medical Records (EMR) included diagnoses of aphasia (condition with disordered or absent language function) muscle weakness, dysphagia (difficulty swallowing), hemiplegia/hemiparesis (weakness and paralysis on one side of the body), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R27's admission Minimum Data Set (MDS) completed 06/09/24 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS indicated she was dependent on staff for bed mobility, transfers, dressing, bathing, and personal hygiene. The MDS indicated she received enteral nutrition through a feeding tube. The MDS indicated she weighed 155 pounds (lbs.) upon admission. R27's Functional Abilities Care Area Assessment (CAA) completed 06/13/24 indicated she admitted to the facility for therapy services related to her medical diagnoses. The CAA indicated she was dependent on staff for all her activities of daily living (ADL). R27's Feeding Tube CAA completed 06/13/24 indicated she was unable to swallow or chew her food safely. The CAA noted she had a percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) for all nutritional intake and was on a nothing by mouth diet (NPO). The CAA indicated she was at risk for complication related to her PEG tube. The CAA indicated the enteral nutrition will be monitored by the registered dietician and medical provider. R27's Nutrition CAA was not triggered upon her admission. R27's Care Plan initiated 06/04/24 indicated she was at risk for alterations with her functional abilities related to her medical diagnoses. The plan noted she was dependent on staff for transfers, dressing, bed mobility, toileting, dressing, bathing, and personal hygiene. The plan indicated she was at risk for altered nutrition and had a PEG tube for enteral nutrition. The plan instructed all medications and nutrition would be administered via her PEG tube. The plan instructed staff to administer her enteral feeding and water flushes per her provided orders. The plan instructed staff to check tube placement and gastric residual volume. The plan instructed staff to hold her enteral feedings if the residual amount was greater than (>) 100 cubic centimeters (cc). (continued on next page)

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	175548	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Actual harm Residents Affected - Few	R27's EMR under Registered Dietician Note indicated R27 was seen by the Registered Dietician (RD) on 06/10/24. The note indicated R27's current body weight was 155.1 lbs. The note indicated R27's diet was NPO and she received enteral nutrition. R27's EMR under Physician's Progress Note indicated the medical provider met with R27 and her resident representative on 06/14/24. The note indicated R27's representative reported R27 had a five-pound weight loss to the medical provider. The note indicated her family was concerned about her nutritional intake and weight loss. The note instructed nursing staff to reweigh R27 accurately and discuss further weight management. The EMR lacked follow-up documentation from the medical provider. R27's EMR under Physician's Orders revealed an order dated 06/04/24 for her to be weighed weekly for four weeks. The order was discontinued on 07/02/24. R27 had no other orders for weight monitoring. R27's EMR under Physician's Orders revealed an order (started 06/03/24) for staff to administer Jevity 1.5 Liter (liquid nutritional supplementation) via PEG tube, twice daily at 55 milliliters (ml) continuously from 08:00 PM to 11:00 AM. The order instructed staff to provide 60 ml water flushes every four hours, prior to enteral feedings. The order was discontinued and reentered on 06/16/24 with no nutritional changes. R27's EMR under Physician's Orders revealed an order (started 06/03/24) for staff to administer 150 ml bolus feedings of Jevity twice daily. The order was discontinued and reentered on 06/16/24 with no nutritional changes. R27's EMR under Weight History between 06/03/24 to 07/09/24 revealed her weight upon admission was 155 lbs. on 06/03/24. The EMR revealed her weight decreased to 143.6 lbs. on 06/11/24, indicating a 7.35% weight loss since her admission to the facility (eight days). R27's EMR indicated her weight decreased to 142. 4 lbs. on 06/20/24, indicating an 8.13% weight loss since her admission (17 days). R27's EMR noted her last recorded weight was 145.2 lbs. on 07/01/24. R27's EMR lacked documentation showing the medical provider or the registered dietician were notified of R27's continued weight loss. Observation on 07/09/24 at 07:04 AM, revealed R27 slept in her bed. The head of R27's bed was propped upward and her nutritional pump was set to 55 ml, with no leaks or spills noted. On 07/10/24 at 08:00 AM staff weighed R27 upon request. She weighed 136.8 lbs. indicating an 11.74% weight loss since her admission (37 days). On 07/10/24 at 09:21 AM R27's representative reported she had concerns related to R27's weight loss. She stated she reported her mother's initial weight loss to the medical provider but had not heard back about what interventions would be put in place or if additional supplementation was needed. She stated the facility had not increased R27's supplementation and feared more weight loss occurred. She stated she didn't feel the current feeding regimen was enough to prevent R27's weight loss and nothing has changed since then. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 07/10/24 at 08:43 AM Licensed Nurse (LN) H stated residents with enteral nutrition should be weighed weekly due to the risk of malnutrition. He stated R27 had a major weight loss identified earlier in the morning and the physician was notified. He stated an order for speech therapy was placed to evaluate her. He stated staff were expected to notify the medical provider and RD upon suspected weight loss. He stated the communication should be documented in the progress notes. He stated resident with enteral nutrition and weight loss should be evaluated to ensure their supplemental nutrition needed to be increased or adjusted. He stated the dietician was at the facility weekly and should evaluate R27's needs if she was at risk. On 07/10/24 at 02:55 PM Administrative Nurse D stated staff should weigh enterally fed residents weekly and report weight loss to the registered dietician. She stated the facility's dietician was on maternity leave and they utilized a temporary RD. She stated the RD came in weekly and should see all residents at risk for weight loss. She stated the RD notes should be charted in the EMR under Progress Notes. On 07/11/24 at 09:25 AM Consultant GG stated she had concerns with the facility's communication related to concerns with weight loss and issues with enteral feedings not being reported to her from staff. She stated she recently met with the facility's management to ensure she was being notified about any dietary concerns reported by staff. She stated she intended to increase R27's enteral feed rate from 55 ml to 65 ml. She stated she expected staff to notify her immediately of findings of significant weight loss. She stated she asked the facility to reweigh R27 yesterday after being notified of the weight loss identified but the facility had yet to notify her of the results. The facility's Nutrition Status Management policy revised 12/2023 indicated the facility was to assess each resident's nutritional needs to ensure their nutritional needs were maintained within acceptable parameters. The policy noted the facility will identify the resident's ideal body weight, associated condition, nutritional preferences, psycho-social needs, and risks. The policy noted at risk resident's will be weighed weekly and reviewed by the dietician. The facility failed to monitor weights and adjust R27's enteral nutrition regimen before a significant weight loss occurred. As a result of the deficient practices, R27 had a significant unplanned weight loss of 11.74% within two months.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. The facility identified a census of 66 residents. The sample included 19 residents with two residents reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to consistently communicate Resident (R) 6's medical condition prior to and post-hemodialysis. This deficient practice placed R6 at risk of potential adverse outcomes and physical complications related to dialysis. Findings included: - R6's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypotension (low blood pressure), end-stage renal disease (ESRD-a terminal disease of the kidneys) with dialysis (procedure where impurities or wastes were removed from the blood), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), hypertension (HTN-elevated blood pressure), muscle weakness, repeated falls, cognitive communication deficit, difficulty in walking, unsteadiness on his feet, and dysphagia (swallowing difficulty). The Annual Minimum Data Set (MDS) for R6 dated 06/12/24 recorded a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R6 required dialysis during the observation period. R6's Functional Abilities CAA dated 06/12/24 documented R6 was a long-term resident due to being legally blind, R6 was able to see shadows. R6 had an alteration in functional abilities and required assistance from staff. R6 was at an increased risk of decline due to his need for assistance with activities of daily living (ADLs). The CAA documented nursing would continue to assist with ADLs to reduce decline. R6's Care Plan dated 07/23/23 documented R6 required hemodialysis related to end-stage renal failure. Nursing staff were to check R6's fistula (abnormal passage from an internal organ to the body surface or between two internal organs) every day for bruit (blowing or swishing sound heard when blood flows through a shunt) and thrill (a fine vibration felt which reflects the blood flow by a dialysis resident's shunt). The plan directed the facility was to save a lunch tray for R6 on dialysis days; nursing staff were to monitor, document, and report to the physician as needed (PRN) any signs or symptoms of infection to the access site. The plan of care dated 10/28/23 documented that the nursing staff was to obtain pre and post-dialysis vitals and report to the physician as needed. Staff were to offer an afternoon snack after dialysis as desired. The plan of care documented R6 would sit for dialysis on Tuesdays, Thursdays, and Saturdays. R6's EMR under the Orders tab dated 08/04/23 revealed the following physician's order: nursing to assess dialysis shunt every shift for signs and symptoms of bleeding. R6's EMR under the Orders tab dated 08/04/23 revealed the following physician's order: Assess and document assessment of fistula for bruit and thrill every shift and as needed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's EMR under the Orders tab dated 08/05/23 revealed the following physician's order: nursing to complete the dialysis communication form after dialysis. R6's EMR under the Orders tab dated 11/05/23 revealed the following physician's order: nursing to obtain a dialysis communication sheet upon return to the facility, nursing to record any new orders and place in R6's medical record in the evening every Tuesday, Thursday, and Saturday, for communication. A review of R6's clinical record including the facility dialysis communication forms lacked evidence of pre- and post-hemodialysis assessment for the dialysis dates of 04/04/24, 04/06/24, 04/16/24, 04/18/24, 05/02/24, 05/04/24, 05/07/24, 05/11/24, and 05/14/24, 05/16/24, 05/21/24, 05/23/24, 05/28/24, 05/30/24, 06/01/24, 06/04/24, 06/06/24, 06/08/24, 06/15/24, 06/18/24, 06/20/24, 06/25/24, 06/29/24, 07/02/24 and 07/4/24. On 07/10/24 at 07:38 AM Licensed Nurse (LN) G stated the process for dialysis communications sheets was when the resident returns from dialysis, the sheet is filled out, or staff call the dialysis center and have the center fax the communication sheet. LN G said staff places the completed sheets in a folder for the Assistant Director of Nursing. On 07/10/24 at 03:05 PM Administrative Nurse D stated the facility was to ensure the communication reports were filled out before the resident left for dialysis. The nurse on duty would ensure the forms were returned or call the dialysis center and have the dialysis center return the sheet. Administrative Nurse D stated the facility had been having problems getting the communication sheets back from the dialysis center. She stated the facility started sending the sheets in a binder in hopes the sheets would be returned. The facility's Dialysis, Pre-and Post Care policy revised on 12/23 documented it was the policy of the facility to assist the resident in maintaining homeostasis pr-and post real dialysis; assess and maintain patency of renal dialysis access; assess resident daily for function related to renal dialysis; participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility failed to consistently communicate R6's medical condition prior to hemodialysis and post-hemodialysis. This deficient practice placed R6 at risk of potential adverse outcomes and physical complications related to dialysis.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility identified a census of 66 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to ensure nurse staffing data was posted daily with the required information and failed to ensure the facility retained the posted daily staffing data as required. Findings included: - On the initial tour of the facility on 07/08/24 at 08:03 AM it was observed that the daily posted staffing hours were from 07/07/24 and the facility census number was omitted. Daily staffing hour sheets were requested from the past 15 months. The facility provided staffing sheets from December 2023 to the present. The review of the sheets revealed the lack of daily sheets from 03/01/24 to 03/21/24, 04/01/24 to 04/09/24, and 04/16/24 to 04/29/24. The daily staffing sheets reviewed from 05/01/24 to the present lacked the daily facility census number. On 07/10/24 at 11:45 AM Administrative Nurse D stated that the front desk staff was responsible for ensuring the daily posted staffing hours was posted. Administrative Nurse D stated the floor charge nurse was responsible on the weekend for ensuring daily staffing was posted. Administrative Nurse D stated she was not aware that the daily staffing hours had omitted the census number. On 07/10/24 at 03:30 PM Administrative Staff A stated the facility did not have a policy specific to the daily posted staffing hours. Administrative Staff A stated staffing ranges were included in the facility assessment and the daily posted staffing hours sheet was posted daily at the front reception desk. The facility failed to ensure nurse staffing data was posted daily with the required information and failed to ensure the facility retained the posted daily staffing data as required.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. The facility reported a census of 66 residents. The sample included 19 with one reviewed for behavioral health services. Based on record review, observations, and interviews, the facility failed to adequately meet Resident (R)46's behavioral health needs related to utilizing non-pharmacological care approaches resulting in repeated behavioral episodes. This deficient practice placed R46 at risk for continued behavioral episodes and unmet care needs. Findings Included: - The Medical Diagnosis section within R46's Electronic Medical Records (EMR) included diagnoses of metabolic encephalopathy (brain disorder resulting in confusion, agitation, and thought dysfunction), cognitive-communication disorder, unsteadiness on her feet, muscle weakness, insomnia (difficulty sleeping), and a need for assistance with personal cares. R46's admission Minimum Data Set (MDS) completed 05/09/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she exhibited verbal and physically aggressive behaviors one to three days of the assessment period. The behavioral assessment indicated her behaviors put her at risk for injury, interfered with her care, and disrupted the care environment. The MDS indicated she required substantial to maximal staff assistance for bed mobility, transfers, bathing, toileting, dressing, and personal hygiene. R47's Behavioral Symptoms Care Area Assessments (CAA) completed 05/13/24 indicated she was at risk for injury related to resisting and refusing care. The CAA noted she had a history of verbal and physical aggression. The CAA indicated her behaviors and risks would be addressed in her care plan. R47's Functional Abilities CAA completed 05/16/24 indicated she had an alteration of her functional abilities and required assistance from staff. The CAA indicated her care needs and risks would be addressed in her care plan. R47's Care Plan initiated 05/06/24 indicated she was at risk for impaired cognitive function related to her medical diagnoses. The plan indicated she had difficulty with communication and instructed staff to make eye contact, identify themselves, eliminate distractions, provide orientation to her surroundings, and allow her to choose by limiting choices (05/06/24). The plan indicated she required substantial to total staff dependence for transfers, dressing, bed mobility, bathing, and toileting (05/06/24). The plan indicated staff was to offer non-pharmacological interventions of reapproaching, repositioning, offering snacks, assessing for pain, offering activities, and providing reassurance when depressed or agitated (05/23/24). The plan lacked interventions related to R47's continued refusal or resistance to care. R47's EMR under Progress Note revealed a nurse's note dated 06/06/24. The note indicated that R47 was still aggressive and verbally abusive towards staff. The note indicated she refused her medications and treatments frequently. The note lacked documentation of what interventions were offered or attempted to calm her down. The note lacked evidence the medical provider was notified of her behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R47's EMR under Progress Note dated 06/11/24 indicated staff attempted to give R47 her evening medication. The note indicated she refused her medication and scratched staff in the face. The note lacked documentation of what interventions were offered or attempted to calm her down. The note lacked evidence the medical provider was notified of her behaviors. R47's EMR under Medication Administration Note revealed a nurse's note dated 06/15/24 indicating R47 had increased agitation as evidenced by yelling, cursing, and calling staff names. The note lacked documentation of what interventions were offered or attempted to calm her down. The note lacked evidence the medical provider was notified of her behaviors. R47's EMR under Progress Note revealed a nurse's note dated 06/30/24. The note indicated that R47 was heard yelling at the nursing aides during care. The note indicated she was swinging her metal cane at them as well. The note lacked documentation of what interventions were offered or attempted to calm her down. The note lacked evidence the medical provider was notified of her behaviors. R47's EMR under Progress Note revealed a nurse's note dated 07/04/24. The note indicated R47 was up for lunch yelling and cussing at staff. The note indicated she was swinging her metal cane at them as well. The note lacked documentation of what interventions were offered or attempted to calm her down. The note lacked evidence the medical provider was notified of her behaviors. On 07/09/24 at 07:45 AM R47 sat in her wheelchair in her room. R47 yelled out Help continuously in her room to get the staff's attention. Staff entered the room within two minutes and asked her if she needed something. R47 stated she did not need anything and excused the staff. R47 continued to yell out for help. Staff reentered the room and offered to assist her with breakfast. R47 was escorted to the dining room area. On 07/10/24 at 10:21 AM Certified Nurse Aide (CNA) M stated staff should attempt interventions to calm down residents that get agitated. She stated the care plan should include interventions that address refusals of care and aggression. She stated if residents refuse bathing or care the nurse is notified. She stated the facility holds mandatory Inservice training for both dementia care and behaviors. On 07/10/24 at 10:40 AM Licensed Nurse (LN) H stated staff were to use the care-planned interventions to help calm agitated or confused residents. She stated R47 had a history of refusing care and becoming easily agitated. She stated staff were to offer multiple attempts for care, reapproach later, and notify the physician if medications were refused. On 07/10/24 at 02:55 PM Administrative Nurse D stated staff should be documenting on the EMR if a resident had frequent refusals or behaviors. She stated the team meets weekly to address and would address repetitive behaviors. She stated refusal interventions she is on the care plans for residents that had known behaviors. She stated behaviors should be documented and reported to the medical provider. The facility's Behavioral Health Services policy revised 01/2024 indicated the facility will provide each resident with the necessary services to attain or maintain the highest practicable physical. Mental, and psychosocial well-being. The policy indicated the facility would assess and implement non-pharmacological interventions. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to adequately meet R46's behavioral health needs related to utilizing non-pharmacological care approaches resulting in repeated behavioral episodes. This deficient practice placed R46 at risk for continued behavioral episodes and unmet care needs.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. The facility identified a census of 66 residents. The sample included 19 with one reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record review, and observations, the facility failed to identify a pattern of dementia-related behaviors for Resident (R)29 and implement meaningful interventions to promote quality of life. This deficient practice placed R29 at risk for preventable injuries and the inability to maintain her highest practicable level of functioning. Findings Included: - The Medical Diagnosis section within R29's Electronic Medical Records (EMR) included diagnoses of dementia, cognitive communication deficit, insomnia (difficulty sleeping), and dysphagia (difficulty swallowing). R29's Significant Change Minimum Data Set (MDS) completed 04/25/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated no behaviors. The MDS indicated she required substantial to maximal assistance with bed mobility, bathing, dressing, toileting, and personal hygiene. The MDS indicated she required set-up assistance with her meals. The MDS indicated she weighed 251 pounds (lbs.). The MDS indicated she was at risk for skin breakdown and utilized pressure-reducing devices in her bed and wheelchair. R29's Dementia Care Area Assessment (CAA) completed 04/30/24 indicated she had an alteration in her cognition. The CAA noted she had poor memory recall and impaired decision-making. R29's Functional Abilities CAA completed 04/03/24 indicated she required staff assistance with all her activities of daily living (ADLs). The CAA indicated a care plan will be completed to reduce the risks related to her falls, skin care, incontinence, and nutrition. R29's Care Plan initiated 07/01/22 indicated she was at risk for alterations in her functional abilities related to her medical diagnoses. The plan indicated she was dependent on staff for transfers, bed mobility, dressing, toileting, bathing, and personal hygiene. The plan indicated she required meal set-up and supervision (07/01/22). The plan noted she was able to manage hot liquids (10/14/22). The plan indicated she had a history of behaviors related to verbal aggression, sexual inappropriateness, and banging on things (10/15/23). The plan instructed staff to approach her in a calm manner, give redirection, and intervene if she is exhibiting behaviors that may injure herself or others (10/15/23). R29's EMR under Progress Notes revealed a note dated 06/20/24. The note revealed R29 was in the dining room for her meal at dinner service. The note revealed she threw her plate on the floor upon receiving her food. The note revealed upon replacing her food plate, R29 began chewing and spitting her food down her shirt. R29's EMR under Progress Notes revealed a note dated 06/25/24. The note revealed staff observed R29 spitting her food down her shirt while yelling for help. The note indicated state brought R29 to the nurse's station and assessed her. The note revealed R29 informed staff she didn't need help and began mocking the nurses. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's EMR under Progress Notes revealed a note dated 06/26/24. The note indicated R29 ordered a grilled cheese sandwich for lunch and sat in the dining room. The note indicated R29 shoved the entire grilled cheese sandwich down her shirt and began screaming for help. The note indicated staff assessed R29 with no injuries and assisted her with cleaning up. R29's EMR under Progress Notes revealed a note dated 07/03/24. The note revealed R29 was in the dining hall waiting for her breakfast. The note indicated staff heard R29 yell out Oh it's hot and was alerted she had poured hot eggs down her shirt. The note indicated she had a bright red burn area on her upper left breast. On 03/21/24 at 02:10 PM Certified Nurses Aid (CNA) M stated R29 sometimes had behaviors but was easily redirected by staff. She stated R29 would have supervision during meals and staff would prompt her if they felt she needed assistance. She stated all staff have access to view the care plan interventions. On 03/21/24 at 02:19 PM Licensed Nurse (LN) G stated R29 required some redirections and monitoring during meals. She stated staff should intervene if residents display behaviors that may harm themselves or others. She stated the facility held yearly dementia-related in-services and used online training for monthly classes. On 03/21/24 at 02:55 PM Administrative Nurse D stated the facility held yearly dementia care training. She stated staff were expected to report concerns related to behaviors to the Interdisciplinary Team so that interventions could be developed. She stated residents with dementia should be monitored closely by staff during mealtimes. She stated staff should prompt and ask the residents about their needs during meal services. The facility's Behavioral Health Services policy revised 01/2024 indicated the facility will provide each resident with the necessary services to attain or maintain the highest practicable physical. Mental, and psychosocial well-being. The policy indicated the facility would assess and implement non-pharmacological interventions. The facility was unable to provide a policy related to dementia care as requested on 07/10/24. The facility failed to identify a pattern of dementia-related behaviors for R29. This deficient practice placed R29 at risk for preventable injuries and the inability to maintain her highest practicable level of functioning.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. The facility identified a census of 66 residents. The sample included 19 residents with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure staff followed physician-ordered parameters for Resident (R) 41 's antihypertensive (class of medication used to treat high blood pressure) medication monitoring. This placed the resident at risk of unnecessary medication administration and possible adverse side effects. Findings included: - R41's Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), myocardial infarction (heart attack), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and chronic kidney disease (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes). R41's Significant Change Minimum Data Set (MDS) dated 01/04/24 documented R41 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R41 had impairment to both upper extremities. R41 required the use of a wheelchair for mobility. R41 required substantial/maximal dependence on staff for functional abilities. R41 required the administration of multiple medications. R41 required oxygen therapy and received hospice services. R41's Quarterly MDS dated 06/22/24 documented a BIMS score of 11 which indicated moderately impaired cognition. R41 had impairment to both upper extremities. R41 required the use of a wheelchair for mobility. R41 required substantial/maximal dependence on staff for functional abilities. R41 required the administration of multiple medications. R41 required oxygen therapy and received hospice services. R41's Functional Abilities Care Area Assessment (CAA) dated 01/08/24 documented R41 was a long-term resident and was recently placed on hospice. R41 had an alteration in self-care related to numerous comorbidities. R41 required assistance with his functional abilities from the staff. R41 required a stand-up lift for transfers. R41's Care Plan lacked staff direction specific to antihypertensive medications. R41's Order Summary Report documented an order dated 04/09/23 for metoprolol succinate (a beta blocker antihypertensive medication) to give one-half tablet by mouth one time a day for HTN hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than 110 or a pulse less than 60. This order was discontinued on 05/26/24. R41's Order Summary documented an order dated 05/26/24 for metoprolol succinate ER oral tablet extended Release 24 Hour 25 MG (metoprolol succinate) to give half a tablet by mouth one time a day for HTN. This order was discontinued on 06/21/24. R41's April 2024 Medication Administration Record (MAR) revealed that R41's pulse lacked monitoring prior to the administration of metoprolol. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's May 2024 MAR revealed a lack of pulse monitoring from 05/01/24 to 05/12/24. The May 2024 MAR lacked blood pressure or pulse monitoring prior to administration from 05/27/24 to 05/31/24. R41's June 2024 MAR revealed a lack of blood pressure or pulse monitoring prior to administration from 06/01/24 to 06/21/24. On 07/10/24 at 08:23 AM R41 sat in his wheelchair at a dining table eating breakfast. R41 had noted intact bandages on bilateral forearms. On 07/10/24 at 01:35 PM Licensed Nurse (LN) H stated that blood pressure and pulse should be taken prior to the administration of blood pressure medications and held per the parameters. LN G stated the medication aide should tell the nurse when a blood pressure or pulse was out of range so the medication could be held if needed. LN G stated the nurse should notify the physician that the medication had been held. On 07/10/24 at 03:25 PM Administrative Nurse D stated that blood pressure and pulse should be monitored prior to the administration of metoprolol. Administrative Nurse D stated she could not say why R41's pulse and blood pressure had not been obtained prior to being administered to R41. The facility policy Medication Administration-General Guidelines revised January 2023 documented that medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications were to be administered in accordance with written orders of the prescriber. The facility failed to ensure R41's blood pressure and pulse were monitored as the physician ordered prior to the administration of metoprolol. This placed R41 at risk for unnecessary medication administration and possible adverse side effects.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility reported a census of 66 residents. The facility identified one medication room and four medication carts. Based on observations, record reviews, and interviews, the facility failed to secure its medication and treatment carts. This deficient practice placed the residents at risk for unnecessary medication and administration errors. Findings Included- - On 07/08/24 at 07:06 AM an inspection of the East Hall nursing station revealed an unlocked skin treatment cart. The cart contained assorted medicated lotions with the avoid ingestion and contact poison control warnings. At 07:20 AM an inspection of the [NAME] Hall station revealed an unsecured medication cart. The cart contained R39's Cefdinir (medication used to treat bacterial infections) and Junuvia (medication used to lower blood glucose) pill packs left unsecured on top of the cart. The medication cart was not secured. The cart stored stock medication and prescription medications for residents in the [NAME] Hall. At 07:25 AM Licensed Nurse (LN) J verified the unsecured medications and medication carts. He stated the carts were to be locked when unsupervised and medication should never be left unattended. He secured the cart. On 07/10/24 at 02:55 PM Administrative Nurse D stated the medication carts were to be locked when not in use or supervised. The facility's Medication Access and Storage policy (undated) indicated all medications and biologicals were to be stored in a safe manner following the manufacturer's storage recommendations. The policy indicated medications should be properly labeled with the recommended expiration dates and stored in a manner appropriate for the specific medication. The facility failed to secure its medication and treatment carts. This deficient practice placed the residents at risk for unnecessary medication and administration errors.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility identified a census of 66 residents. The facility identified eight residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control standards related to the handling of soiled laundry, medication administration, and disposal of personal protective equipment (PPE). These deficient practices placed the residents at risk for infectious diseases. Included Findings: - On 07/08/24 at 07:21 AM soiled towels were placed on the ground for a large leak in front of the drink station of the [NAME] Hall kitchenette. On 07/08/24 at 08:01 AM a soiled glove and broken facemask were left on top of the EBP cart outside of R48's room. On 07/09/24 at 07:25 AM a pile of bed linen was on the floor of R39's floor. On 07/09/24 at 07:28 AM, soiled damp towels and clothing were placed on the floor of R6's room next to the bathroom. On 07/09/24 at 12:15 PM Certified Medication Aide (CMA) T failed to complete hand hygiene while preparing and administering medications for R45. On 07/09/24 at 02:42 PM, used PPE lay on the floor of R5's room. On 07/10/24 at 07:04 AM CMA S failed to complete hand hygiene after touching multiple surfaces during medication administrations for R12. On 07/10/24 at 07:26 AM R39 was standing, holding onto the handrail in the bathroom. Certified Nurse's Aide (CNA) O laid the peri wipes package in R39's wheelchair and took several out and laid the wipes on the wheelchair seat. CNA O donned gloves and wiped R39's bottom. R39 had a bowel movement. CNA O then wiped R39's front peri area, doffed her gloves, and donned a second pair of gloves without performing hand hygiene. CNA O then wiped R39's front peri area, doffed her gloves, and pulled R39's brief and pants up without performing hand hygiene first. CNA O helped R39 into her wheelchair, flushed the toilet, picked up the trash bag, and then used hand sanitizer when leaving R39's room. CNA O stated she should have performed hand hygiene before donning gloves and should have washed her hands when she was finished with toileting R39. CNA O stated the facility had not done education since she started on hand hygiene. On 07/10/24 at 09:45 AM, CNA M stated soiled towels and linen were to be placed in the soiled linen rooms. She stated hand hygiene should be completed before, during, and after contact with residents or contaminated surfaces. On 07/10/24 at 10:00 AM Licensed Nurse (LN) G stated hand hygiene was to be completed frequently during medication pass to ensure the medications and surrounding surfaces were not contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/10/24 at 02:55 PM Administrative Nurse D stated staff were expected to complete hand hygiene in between cares and residents. She stated direct care staff were expected to dispose of laundry in the soiled linen rooms and never place them on the floor. She stated hand hygiene should be completed in between PPE and glove changes. The facility's Infection Control and Surveillance policy revised 10/2023 indicated infection control and prevention training would be completed routinely. The policy indicated staff would be educated on the use of proper hand hygiene and practices to reduce the risks of preventable infections and illness. The policy indicates the facility will educate staff on the proper management of the resident's environment and infection control standards to manage equipment, environment, personal care, and treatments. The facility failed to follow sanitary infection control standards related to the handling of soiled laundry, medication administration, and disposal of PPE. These deficient practices placed the residents at risk for infectious diseases.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. The facility identified a census of 66 residents. Based on record review and interviews, the facility failed to ensure agency direct care staff had received the required communication training. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 07/10/24 at 10:40 AM a review of the training for agency Certified Nurses Aid (CNA) P, CNA Q, and CNA LL revealed the following: CNA P's facility-provided credentialling file lacked evidence training was completed for communication training. CNA Q's facility-provided credentialling file lacked evidence training was completed for communication training. CNA LL's facility-provided credentialling file lacked evidence training was completed for communication training. On 07/10/24 at 10:45 AM Administrative Staff A stated during orientation with the agency employees, staff go over the curriculum with agency staff which included timekeeping and meal breaks, the smoking policy, cell phone and social media, the dress code, dietary services, fall prevention, infection control, abuse, customer service and information related to the protected health information and electronic medical record. Administrative Staff A stated he assumed that the staffing agency made sure that agency staff had completed the required in-services for nurse aides. Administrative Staff A stated he would ensure that communication, resident rights, and dementia training were added to the curriculum for agency staff. The facility failed to ensure agency direct care staff had received communication training. This placed the residents at risk for impaired care and decreased quality of life.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. The facility identified a census of 66 residents. Based on record review and interviews, the facility failed to ensure agency direct care staff had received the required resident's rights training. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 07/10/24 at 10:40 AM a review of the training for agency Certified Nurses Aid (CNA) P, CNA Q, and CNA LL revealed the following: CNA P's facility-provided credentialling file lacked evidence training was completed for resident's rights training. CNA Q's facility-provided credentialling file lacked evidence training was completed for resident's rights training. CNA LL's facility-provided credentialling file lacked evidence training was completed for resident's rights training. On 07/10/24 at 10:45 AM Administrative Staff A stated during orientation with the agency employees, staff go over the curriculum with agency staff which included timekeeping and meal breaks, the smoking policy, cell phone and social media, the dress code, dietary services, fall prevention, infection control, abuse, customer service and information related to the protected health information and electronic medical record. Administrative Staff A stated he assumed that the staffing agency made sure that agency staff had completed the required in-services for nurse aides. Administrative Staff A stated he would ensure that communication, resident rights, and dementia training were added to the curriculum for agency staff. The facility failed to ensure agency direct care staff had received resident's rights training. This placed the residents at risk for impaired care and decreased quality of life.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility identified a census of 66 residents. Based on record review and interviews, the facility failed to ensure agency direct care staff had received the required dementia training for nurse aides. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 07/10/24 at 10:40 AM a review of the training for agency Certified Nurses Aid (CNA) P, CNA Q, and CNA LL revealed the following: CNA P's facility-provided credentialling file lacked evidence the required in-service training was completed for nurse aides. CNA Q's facility-provided credentialling file lacked evidence the required in-service training was completed for nurse aides. CNA LL's facility-provided credentialling file lacked evidence the required in-service training was completed for nurse aides. On 07/10/24 at 10:45 AM Administrative Staff A stated during orientation with the agency employees, staff go over the curriculum with agency staff which included timekeeping and meal breaks, the smoking policy, cell phone and social media, the dress code, dietary services, fall prevention, infection control, abuse, customer service and information related to the protected health information and electronic medical record. Administrative Staff A stated he assumed that the staffing agency made sure that agency staff had completed the required in-services for nurse aides. Administrative Staff A stated he would ensure that communication, resident rights, and dementia training were added to the curriculum for agency staff. The facility failed to ensure agency direct care staff had received the required in-service for nurse aide training. This placed the residents at risk for impaired care and decreased quality of life.