| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175181 | A. Building<br>B. Wing | 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Larksfield Place | 2828 N. Governeour<br>Wichita, KS 67226 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056<br><br>The facility reported a census of 74 residents with 20 residents sampled for review, including one resident reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set (MDS) for one Resident (R)70, regarding discharge to an acute hospital.<br><br>Findings included:<br><br>- Review of Resident (R)70's electronic medical record (EMR) included a diagnosis of type II diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).<br><br>The Modification of Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted to the facility on [DATE], from an acute hospital. She had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident's overall goal was to discharge to the community.<br><br>The Return to Community Referral Care Area Assessment (CAA), dated 06/23/24, did not trigger.<br><br>The Discharge MDS, dated [DATE], documented the resident discharged from the facility to an acute hospital on 07/09/24. She had a BIMS score of 14, indicating intact cognition.<br><br>The baseline care plan, dated 06/19/24, documented the resident's goal was to discharge to the community with home health.<br><br>Review of the resident's EMR revealed a physician's order for the resident to discharge to home, ordered 07/09/24.<br><br>Review of the resident's EMR revealed a Discharge Summary, dated 07/09/24.<br><br>Review of the resident's EMR included documentation that the resident discharged to home on 07/09/24 at 02:15 PM.<br><br>On 10/09/24 at 11:35 AM, Administrative Nurse F stated the resident did not discharge to an acute hospital but had discharged to home. The Discharge MDS, dated [DATE], was inaccurate.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility utilized the Resident Assessment Instrument (RAI) for the accurate completion of MDSs.<br><br>The facility failed to complete an accurate discharge MDS for this resident who discharged to home. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056<br><br>The facility identified a census of 74 residents with 20 residents sampled, including two residents reviewed for positioning. Based on observation, interview, and record review, the facility failed to ensure proper wheelchair positioning for one Resident (R)5.<br><br>Findings included:<br><br>- Review of Resident (R)5's electronic medical record (EMR) included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).<br><br>The Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. She was dependent on staff for mobility in her wheelchair and all transfers.<br><br>The Functional Abilities Care Area Assessment (CAA), dated 10/03/23, did not trigger.<br><br>The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe impairment. She was dependent on staff for mobility in her wheelchair and transfers.<br><br>The care plan for Activities of Daily Living (ADL), revised 07/29/24, instructed staff the resident had impaired cognition and was dependent on staff for wheelchair mobility.<br><br>Review of the resident's EMR, from 06/07/24 through 10/07/24, revealed the resident was dependent on staff for wheelchair mobility.<br><br>On 10/07/24 at 11:01 AM, the resident sat in her wheelchair. Her left ankle crossed over her right ankle and her right foot dangled above the footrest of the wheelchair.<br><br>On 10/08/24 at 08:53 AM, the resident sat in her wheelchair in the commons area. Her left ankle crossed over her right ankle and her right foot dangled above the footrest of the wheelchair.<br><br>On 10/08/24 at 12:51 PM, the resident sat in her wheelchair near the nurses' desk. Her left ankle crossed over her right ankle and her right foot dangled above the footrest of the wheelchair.<br><br>On 10/08/24 at 10:51 AM, Certified Nurse Aide (CNA) O stated the resident's feet did not come down far enough to rest on the footrests of the wheelchair.<br><br>On 10/08/24 at 11:15 AM, CNA N stated the resident's feet did not usually come down far enough to reach the footrests of the wheelchair.<br><br>On 10/08/24 at 01:07 PM, Licensed Nurse (LN) I stated she had not noticed the resident's feet not reaching the footrests of her wheelchair.<br><br>On 10/09/24 at 08:16 AM, Administrative Nurse D stated therapy would need to evaluate the resident to determine if the resident's feet should reach the footrests.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy for Wheelchair Mobility/Use of Footrests, dated 09/06/19, included: The facility shall keep all residents safe and to protect them from injury. Staff shall apply footrests to the wheelchair and place the resident's feet flat on the footrests.<br><br>The facility failed to ensure proper wheelchair positioning for this dependent resident. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056<br><br>The facility reported a census of 74 residents with 20 residents sampled, including nine residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure one Resident (R)3's toilet safety rail was secure and R 29, related to failure to ensure the resident was safe in the use of his lift chair.<br><br>Findings included:<br><br>- Review of Resident (R)3's electronic medical record (EMR) revealed the resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).<br><br>The Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. She has no impairment in functional range of motion (ROM) and was dependent on staff for toileting hygiene.<br><br>The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 07/13/24, documented the resident was dependent on staff for toileting cares.<br><br>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of three, indicating severe cognitive impairment. She has no impairment in functional ROM and was dependent on staff for toileting hygiene.<br><br>The urinary incontinence care plan, revised 07/22/24, instructed staff the resident was dependent with toileting hygiene.<br><br>Review of the EMR, from 08/01/24 through 10/07/24, revealed the resident was dependent on staff for toileting transfers and toileting hygiene.<br><br>On 10/07/24 at 10:59 AM, the toilet safety rail in the resident's private bathroom was extremely loose and lacked the rubber boot where the rail met the floor.<br><br>On 10/08/24 at 08:41 AM, the toilet safety rail in the resident's private bathroom was extremely loose and lacked the rubber boot where the rail met the floor.<br><br>On 10/08/24 at 11:07 AM, Certified Nurse Aide (CNA) M and CNA P transferred the resident from her wheelchair to the toilet with the sit to stand mechanical lift (helps transfer patients from one seated surface to another) and placed her on the toilet. The resident rested her right arm on the toilet safety rail on the right side of the toilet. The safety rail moved several inches while the resident's arm rested on the rail.<br><br>On 10/09/24 at 10:12 AM, Housekeeping/Maintenance staff U stated he checked the toilet safety rails monthly and had not seen the rubber boot missing from the resident's toilet safety rail.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/09/24 at 08:16 AM, Administrative Nurse D stated it was the expectation for resident equipment to be in good condition.<br><br>The facility policy for Preventive Maintenance and Inspections, undated, included: The facility shall provide a safe environment for residents and promote the maintenance of fixtures and equipment in a state of good repair and condition.<br><br>The facility failed to ensure this dependent resident's toilet safety rail was secure.<br><br>- Review of Resident (R)29's electronic medical record (EMR) revealed a diagnosis of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).<br><br>The Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. He was dependent on staff for chair to bed to chair transfers, had no limitation in range of motion (ROM) and had not had any falls since his prior assessment.<br><br>The Falls Care Area Assessment (CAA), dated 04/26/24, did not trigger.<br><br>The Functional Abilities CAA, dated 04/26/24, documented the resident had impaired balance during transfers and required staff assistance.<br><br>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 12, indicating moderately impaired cognition. He was dependent on staff for chair to bed to chair transfers, had no limitation in ROM and had not had any falls since his prior assessment.<br><br>The care plan for safety, revised 07/26/24, instructed staff the resident was at risk for falls related to a history of falls prior to admission, impaired mobility, and a diagnosis of Parkinson's disease.<br><br>Review of the resident's EMR revealed the fall assessments which placed him at a high risk for falls, dated: 10/03/23, 08/25/24 and 10/08/24.<br><br>Review of the resident's EMR revealed a lift chair assessment, dated 02/28/22, which indicated the resident was safe to use his lift chair recliner.<br><br>Review of the resident's EMR revealed a lift chair assessment, dated 08/25/24 and 08/26/24, which indicated the use of a lift chair remote and/or chair was a safety risk.<br><br>No other lift chair assessments were available.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's EMR revealed on 08/25/24, at 08:15 AM, staff observed the resident on the floor of his room, resting on his left side, in front of the lift recliner which was in the fully extended position. The alert and oriented resident with confusion stated he had tried to get up to walk on his own and had fallen. The resident complained of left hip pain and no had no other obvious injuries, at that time. Staff assisted the resident back into his lift reclining chair and unplugged the recliner. Staff obtained a physician's order for a mobile x-ray of the left hip which showed no acute fracture.<br><br>On 10/08/24 at 12:53 PM, a family member stated the resident had experienced increased confusion in August 2024. The resident utilized the remote control to raise his chair to a fully upright position and fell to the floor. The facility unplugged the lift chair and removed the remote control of the recliner from his room.<br><br>On 10/08/24 at 10:51 AM, Certified Nurse Aide (CNA) O stated the resident's lift chair was unplugged due to him not being able to safely use the chair on his own. He had an increase in confusion and had lifted the chair fully upright and fallen from the chair.<br><br>On 10/08/24 at 12:57 PM, CNA M stated the resident had been really confused when he used his remote control to lift his chair all the way up, causing him to fall to the floor. Since that time, the chair has been kept unplugged.<br><br>On 10/08/24 at 01:07 PM, Licensed Nurse (LN) I stated lift chair assessments were not done on a routine basis.<br><br>On 10/09/24 at 08:16 AM, Administrative Nurse E stated the resident experienced an increase in confusion at the time of his fall. Administrative Nurse E confirmed staff had not completed a lift chair assessment, at that time.<br><br>On 10/09/24 at 08:16 AM, Administrative Nurse D stated staff were to complete lift chair assessments upon admission, with significant changes and following a fall from a lift chair. A resident would be considered safe to use a lift chair if they were able to demonstrate safe usage of the chair and remote control. Administrative Nurse D confirmed staff had not completed a lift chair assessment with the resident's significant change on 04/26/24.<br><br>The facility policy for Lift Recliner Chair Policy, undated, included: Residents will be assessed for safe use of a lift recliner chair upon admission, after a fall, or upon experiencing a significant change in condition.<br><br>The facility failed to complete a lift chair assessment for this dependent resident with a significant change in condition. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 74 residents with 20 residents selected for review, which included two residents reviewed for urinary catheters (a flexible tube inserted through the urethra [the external opening of the urinary tract] and into the bladder). Based on observation, interview, and record review, the facility failed ensure consistent monitoring of one Resident (R)58's penile erosion (a split in the urethra) caused by pressure of a urinary catheter.<br><br>Findings included:<br><br>- Review of Resident (R)58's medical record revealed diagnoses that included urinary retention (inability to empty urine from the bladder), renal failure, history of repair of femur (long bone in the upper leg), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive function. The resident had impairment on one side of the lower extremities and utilized a walker/wheelchair. The resident had a urinary catheter (a flexible tube that is inserted through the urethra [the external opening of a small tubular structure that drains urine from the bladder] and into the bladder to drain urine into a collection bag).<br><br>The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 07/20/24, assessed the resident required assistance with toileting needs and incontinent episodes.<br><br>The Care Plan reviewed 07/22/24, 08/12/24 and 10/08/24, instructed staff with the following interventions:<br><br>On 08/12/24, the day nurse was to provide a leg bag (a slim bag low volume bag that attached to the leg) for urinary drainage daily, and a night bag (a large volume urine collection bag) at bedtime.<br><br>Staff instructed to change the catheter monthly and as needed. Staff were to cleanse the upper right and left side of the urethral opening and down the shaft with a wound cleanser or normal saline, pat dry, and reapproximate (bring back together) the skin if able. Staff were to apply steri strips (a type of adhesive medical tape used to approximate edges) every three days if needed, and as needed if the dressing gets wet. Staff were to make sure the catheter anchor was applied securely. Staff were to provide catheter care every shift and refer to urology as needed.<br><br>A Physician's Order dated 08/08/24, instructed staff to insert a size 16 French (a type of catheter) urinary catheter with a 10-millimeter bulb (a balloon on the tip of the catheter to hold the catheter in place in the bladder and provide catheter care twice a day for hydronephrosis (a build-up of urine in the kidneys) and urinary retention.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Nurse Note dated 09/13/24, documented R58's catheter care as completed, and the nurse noticed a small split to the penis. The nurse applied an ointment containing vitamin A and vitamin D, and educated the resident on the importance of the catheter anchor placement and effects of tugging on the catheter, and informed the nursing manager.<br><br>A Nurse Note dated 09/17/24, documented the nurse completed catheter care, and noted a split in the resident's penis which measured 3 by 2 (no indication of unit of measure). Documentation revealed the resident occasionally pulled on the catheter and staff educated the resident , and the wound nurse and the medical team notified.<br><br>A Physician's Order dated 09/18/24 , instructed staff to cleanse the upper right and left side of the urethral opening and down the shaft with wound cleanser or normal saline, pat dry and reapproximate the skin if able with steri strips every three days and as needed. Staff instructed to ensure the catheter anchor was in place and secure.<br><br>A Physician's Order dated 10/08/24, instructed staff to cleanse the penile erosion with normal saline (a solution used for cleansing wounds), pat dry, approximate the edges of the wound with steristrips, and cover the penis with a mesh sleeve or wrap with Kerlix and secure, daily, and as needed until healed.<br><br>Review of the September 2024 Treatment Administration Record (TAR) revealed staff provided catheter care three times a day, (on each shift). The resident refused the care on 14 occasions, on the night shift. The resident received the daily care to the penile erosion without refusal.<br><br>Review of the October 2024 TAR revealed the resident refused the night shift catheter care three times.<br><br>Interview, on 10/08/24 at 09:26 AM with Licensed Nurse (LN) I, revealed the resident did cooperate with care of the penis erosion and staff ensured the catheter anchor was in place. LN, I stated the wound did not appear to improve but she did not measure the area.<br><br>.<br><br>Interview, on 10/08/24 at 10:15 AM, with Consultant Nurse HH, revealed she did not visualize the wound at the time of giving orders for treatment and would expect staff to document the effectiveness of the treatment.<br><br>Interview on 10/08/24 at 11:02 AM, with Administrative Staff F revealed staff notified her of the wound on 09/18/24 and provided orders for treatment but did not visualize the wound at that time. Administrative Nurse F stated she used a phone application (app) that would take a picture of the wound and the application would provide measurements and documents the wound in the electronic medical record in the Wound and Skin Assessment tab but had not done so (20 days after notification).<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 10/08/24 at 11:10 AM, revealed the resident cooperative with examination of the penile erosion. The posterior area of the penis revealed the urethra split revealing a beefy red appearance of the tissue. The resident's penis lacked steri strips, however the catheter tubing was anchored. The resident denied pain. Administrative Nurse F obtained measurements with the phone app and obtained measurements of a length of 1.7 centimeters (cm) and a width of 0.8 cm. Administrative Nurse F cleansed the wound with normal saline, dried the area and applied steri strips. Consultant Nurse HH stated the resident may benefit from a urology consult and may be a candidate for a supra pubic catheter (a catheter that is inserted into the bladder through the abdominal wall).<br><br>Interview, on 10/09/24 at 10:00 AM with Administrative Nurse D, revealed the facility had a treatment in place and was provided by the day shift nurse but did not realize the resident refused the night shift catheter care. Administrative Nurse D stated the Wound Nurse was responsible for monitoring wounds to determine the effectiveness of the treatments.<br><br>Interview on 10/09/24 at 10:30 AM with Consulting Physician GG, revealed the erosion was probably due to the urinary catheter, and did not have a concern regarding treatment provided to ensure the catheter was secured in place appropriately.<br><br>The facility policy Pressure Injury Prediction, Prevention and Treatment Program dated 01/11/24, instructed staff to notify the wound nurse who will utilize the electronic wound app for documentation of the wound to include location, size, length width depth and description the wound bed tissues, edges, and surrounding tissues. The interdisciplinary care plan team will evaluate the plane of care, and the wound team will evaluate wounds routinely until healed.<br><br>The facility failed to ensure staff monitored this resident's penile erosion to determine the effectiveness of treatment to prevent further injury and infection. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 74 residents with 20 residents selected for review, which included six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure staff followed physician orders for medication for one Resident (R)52 who received a lower dose a chemotherapy (medication used to treat cancer) than ordered by the physician.<br><br>Findings included:<br><br>- Review of Resident (R)52's electronic medical record revealed diagnoses that included malignant (cancerous) neoplasm (tumor) of the brain, and post operative repair of femur (bone in upper part of the leg) fracture.<br><br>The Admission Minimum Data Set (MDS) dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function.<br><br>The ADL (Activity of Daily Living) Functional/Rehabilitation Care Area Assessment (CAA), dated 09/30/24, assessed the resident required skilled therapies after a left hip fracture and neoplasm of the brain and required assistance with ADLs due to impaired balance.<br><br>The Care Plan dated 10/07/24, instructed staff to monitor the resident for effectiveness of<br><br>pain medication. The resident desired to return home.<br><br>A Physician's Order dated 10/04/24, instructed staff to administer Temozolomide (a medication used to slow or stop the growth of cancerous brain tumors), 240 milligrams (mg) daily, on an empty stomach (one hour before eating), for five days, for brain neoplasm, and repeat every four weeks.<br><br>Review of the Medication Administration Record (MAR), for October 2024, revealed the resident received 240 mg of Temozolomide on 10/05/24, 10/06/24 and 10/07/24.<br><br>Interview, on 10/07/24 at 10:43 AM, with the resident, revealed she was concerned with the administration of her chemotherapy medications and thinks staff did not provide the correct dose.<br><br>Interview, on 10/08/24 at 08:15 AM, with the resident, revealed she had not received her 08:00 AM dose of Temozolomide, and her breakfast had been delivered and she did not want to eat it until she received her medication, and then waited an hour.<br><br>Interview, on 10/08/24 at 08:15 AM, with Licensed Nurse K, revealed she was awaiting delivery from a pharmacy so she could administer the correct dose.<br><br>(continued on next page) |

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|---|---|---|---|
| | 175181 | A. Building<br>B. Wing | 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Larksfield Place | 2828 N. Governeour<br>Wichita, KS 67226 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview, on 10/08/24 at 08:30 AM, with Administrative Nurse EE, confirmed the resident received 200 mg of Temozolomide on 10/05/24 instead of the ordered 240 mg. Administrative Nurse EE stated the medication was special ordered from the pharmacy and was available in 100 mg and 140 mg capsules, and the facility initially received 5 capsules of each dose. Administrative Nurse EE stated the resident received two of the 100 mg capsules on 10/05/24 and thought perhaps one of the 100 mg capsules was dropped on the floor and discarded, so the pharmacy had to send out more of the 100 mg capsules<br><br>Interview on 10/08/24 at 01:30 PM, with Licensed Nurse H, confirmed the resident received 200 mg of Temozolomide, on 10/05/24.<br><br>The facility policy Medication Administration Policy dated 01/11/24, instructed staff to administer medication to residents as ordered by the physician.<br><br>The facility failed to ensure staff administered the correct dose of Temozolomide as ordered by the physician to ensure effective treatment for cancerous brain tumor for this resident. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34056<br><br>The facility reported a census of 74 residents. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne bacteria, by failing to ensure the ice machine had an appropriate drainage air gap from the tubing to the floor drain, as required.<br><br>Findings included:<br><br>- During an initial tour of the kitchen on 10/07/24 at 10:35 AM, revealed the facility ice machine, used to supply ice to residents of the facility, did not have appropriate drainage. The draining tube from the ice machine fed directly into the floor drain, which contained small pieces of trash and debris, and lacked an air gap, as required.<br><br>On 10/07/24 at 10:44 AM, Dietary Staff BB stated the draining tube from the ice machine should go into the floor drain.<br><br>The facility policy for Ice Machine Safety, undated, included: The ice machine will be maintained and cleaned by the Environmental Service Staff.<br><br>The facility failed to ensure the ice machine had an appropriate drainage air gap from the tubing to the floor drain, as required. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056<br><br>The facility reported a census of 74 residents with 20 residents sampled, including five residents reviewed for indwelling urinary catheter (a thin, hollow tube that is inserted into the bladder through the urethra to drain and collect urine). Based on observation, interview and record review, the facility failed to provide appropriate catheter care for two Residents (R)47, and R58 with indwelling urinary catheters, in a clean and sanitary manner.<br><br>Findings included:<br><br>- Review of Resident (R)47's electronic medical record (EMR) revealed a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying).<br><br>The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. He had an indwelling urinary catheter (a thin, hollow tube that is inserted into the bladder through the urethra to drain and collect urine) and was dependent on staff for toileting needs.<br><br>The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 09/27/24, documented the resident had an indwelling urinary catheter due to a neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).<br><br>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of two, indicating severe cognitive impairment. He had an indwelling urinary catheter and was dependent on staff for toileting needs.<br><br>The bowel and bladder care plan, revised 09/23/24, instructed staff to provide daily catheter care, every shift.<br><br>Review of the resident's EMR, revealed the following physician's order:<br><br>Licensed Nurse (LN) to provide catheter care every shift, ordered 09/29/23.<br><br>On 10/07/24 at 09:39 AM, the resident sat in his recliner in his room, with the door open. The resident's catheter bag rested directly on the floor and lacked a dignity bag.<br><br>On 10/08/24 at 11:25 AM, the resident sat in his recliner in his room, with the door open. The resident's catheter bag was half in and half out of a dignity bag and rested directly on the floor.<br><br>On 10/08/24 at 10:51 AM, Certified Nurse Aide (CNA) O stated all catheter bags should be kept in a dignity bag.<br><br>On 10/08/24 at 11:25 AM, LN I stated staff should ensure catheter bags are always kept in a dignity bag.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/09/24 at 08:16 AM, Administrative Nurse D stated it was the expectation for staff to ensure resident's catheter bags are always kept fully inside a dignity bag.<br><br>The facility policy for Catheters, dated 01/08/18, included: Catheter drainage bags shall be covered when the resident was out of the room or up in their chair.<br><br>The facility failed to ensure this dependent resident's indwelling catheter bag was kept off of the floor at all times.<br><br>28560<br><br>- Review of Resident (R)58's medical record revealed diagnoses that included urinary retention (inability to empty urine from the bladder), renal failure, history of repair of femur (long bone in the upper leg), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness).<br><br>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive function. The resident had impairment on one side of the lower extremities and utilized a walker/wheelchair. The resident had a urinary catheter (a flexible tube that is inserted through the urethra [the external opening of a small tubular structure that drains urine from the bladder] and into the bladder to drain urine into a collection bag).<br><br>The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 07/20/24, assessed the resident required assistance with toileting needs and incontinent episodes.<br><br>The Care Plan reviewed 07/22/24, 08/12/24 and 10/08/24, instructed staff with the following interventions:<br><br>On 08/08/24, the day nurse was to provide a leg bag (a slim bag low volume bag that attached to the leg) for urinary drainage daily, and a night bag (a large volume urine collection bag) at bedtime.<br><br>Staff instructed to change the catheter monthly and as needed. Staff were to provide catheter care every shift and refer to urology as needed.<br><br>A Physician's Order dated 08/08/24, instructed staff to insert a size 16 French (a type of catheter) urinary catheter with a 10-millimeter bulb (a balloon on the tip of the catheter to hold the catheter in place in the bladder and provide catheter care twice a day for hydronephrosis (a build-up of urine in the kidneys) and urinary retention.<br><br>Observation, on 10/08/24 at 11:10 AM, revealed the resident seated in his wheelchair. The leg bag was attached to his right lower leg. The drain spout hung down from the lower edge of the bag and lacked a protective cap to keep it from touching unclean surfaces.<br><br>Interview, on 10/08/24, at 11:10 AM, with Administrative Nurse F, confirmed the lack of drain cover, and after investigation, discovered the supplier sent the wrong leg bags and she would replace the resident's current leg bag with a leg bag with a protective cap.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy Catheters dated 01/11/24, instructed staff to ensure the appropriate treatment and services are provided to the resident to prevent and/or treat urinary tract infections.<br><br>The facility failed to ensure staff provided sanitary enclosed urine collection bag for this resident to prevent contamination/infection. |