STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175226	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Iola	600 E Garfield Street Iola, KS 66749

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 28560 - Observation on 01/23/24 and 01/24/23 of Resident (R)1's room revealed the floor with multiple areas of a sticky substance. The over bed table contained rust and a build-up of grime on the base of the table. The room contained a recliner with multiple pillows without pillowcases, and the resident's dresser tops contained unorganized supplies and personal items. Interview, on 01/24/24 at 08:06 AM, Licensed Nurse (LN) H, revealed the resident remained in bed most of the time. LN H stated the floor was dirty and the room needed to be cleaned. Interview, on 01/24/24 at 10:37 AM, with Housekeeping Staff U, revealed housekeeping cleaned R1's room every other day as the resident was in isolation. Housekeeping Staff U stated nursing staff would be responsible for organization of items in the resident rooms. The facility policy Resident Room Cleaning undated, instructed staff to daily clean resident rooms, pick up all trash, mop the floor, move furniture and beds to thoroughly clean. The facility failed to ensure staff maintained this dependent resident's room in a sanitary and homelike manner to enhance the resident's sense of wellbeing. 34056 The facility reported a census of 34 residents. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable and homelike environment in three resident rooms and one of two medication rooms. Findings included: - During the survey process, the following areas of concern were noted in the facility: 1. An unopened box of tube feeding supplies, quantity unknown, rested directly on the floor in the medication room. 2. One resident room had a fall mat with multiple tears which made it unsanitizable. The resident's room also had a build-up of dirt and grime around the parameter of the room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. One resident's room had a headboard with large areas of missing and/or chipped varnish, making it unsanitizable. The facility policy for Infection Management Process, revised 11/2023, included: All resident rooms will have standard housekeeping services at least daily. The facility failed to maintain a clean, comfortable and homelike environment in these resident rooms and medication room.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 34 residents with 16 selected for review. Based on observation, interview and record review, the facility failed to revise one Resident (R)1's care plan to include care and treatment of her urinary catheter and failed to revise R4's care plan to include use of a pressure reducing device when sitting in her recliner. Findings included: - Review of Resident (R)1's Physician Order Sheet, dated 01/02/24, revealed diagnoses that included neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), muscle weakness, arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement) and neuralgia (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The resident required substantial/maximal assistance with toileting and was always incontinent of urine. The ADL (Activities of Daily Living) Functional /Rehabilitation Care Area Assessment (CAA), dated 07/19/23, assessed the resident required extensive assistance of one to two staff for toilet use and peri care. The Quarterly MDS, dated [DATE], assessed the resident with a BIMS score of 12 which indicated moderate cognitive impairment. The resident had no pressure ulcers but had moisture associated skin damage (inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous). The resident was always incontinent of urine. The Care Plan reviewed 12/29/23, instructed staff the resident had sensory unawareness of urinary incontinence and to check and change and provide peri care every two to three hours as needed. The Care Plan lacked an update for instruction of the care and treatment of this resident's urinary catheter. On 01/09/24, the physician order instructed staff to insert a urinary catheter for bladder drainage due to the resident's neurogenic bladder. Observation, on 01/24/23 at 09:50 AM, revealed the resident positioned in bed. Licensed Nurse H and Certified Nurse Aide OO repositioned the resident in her bed. The resident's urinary catheter bag was attached to the bed frame with the lower part of the bag directly on the floor. The anchoring device for the catheter was not attached to the resident as it was twisted and stuck to itself around the catheter tubing. CNA OO and LN H provided peri care to the resident and repositioned the resident onto her right side. LN H stated the resident should have an anchoring device on the catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 01/24/24 at 2:24 PM revealed CNA PP, repositioned the resident so she could eat lunch. CNA PP placed a pillow under the resident's legs and repositioned the urinary catheter. The urinary catheter lacked an anchoring device. Observation, on 01/25/24 at 10:58 AM, revealed the resident positioned in bed. Certified Nurse Aide (CNA) OO and (LN) I positioned the resident onto her left side for dressing change. The resident's bed linen contained wrinkles beneath her back and lower back. The resident's urinary catheter had the same nonfunctional twisted anchoring device adhered to itself around the catheter tubing, and no functional anchoring device to secure the catheter to prevent dislodgement or tearing of the urethra (small tubular structure that drains urine from the bladder). Interview, on 01/25/24 at 12:29 PM, with Administrative Nurse D, confirmed the January 2024 Medication Administration Record/ Treatment Administration Record (MAR/TAR) and the Care Plan lacked instruction for care of the urinary catheter and would expect licensed staff to ensure documentation on the MAR/TAR and Care Plan. Interview, on 01/25/24 at 12:29 PM, with Administrative Nurse D, revealed she would expect licensed nurses to update the care plan when they have a new order or treatment. The Medication Administration Record/Treatment Administration Record also should be updated. The facility policy Electronic Care Plan revised 12/20, instructed staff the person-centered plan of care reflects the care needs and voice of the resident. The facility failed to revise the Care Plan to include this resident's urinary catheter. - Review of Resident (R)4's medical record, revealed diagnoses included heart failure, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) and muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8 which indicated severe cognitive impairment. The Significant Change Minimum Data Set (MDS), dated [DATE], lacked assessment of the residents mental status and assessed the resident with two stage two pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction stage two partial thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) and one stage three pressure ulcer(full thickness pressure injury extending through the skin into the tissue below) present upon admission. The resident required substantial/maximum assistance with activities of daily living and transfers. The Pressure Ulcer Care Area Assessment (CAA) dated 12/15/23 assess the resident admitted with two stage two pressure ulcer and one stage three pressure ulcer on each buttock and coccyx (lower area of spine). The resident wore briefs for incontinence. The resident was able to reposition herself, but staff assisted the resident to turn and reposition every two hours and provide prompted toilet opportunity to the resident. The resident received hospice services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan reviewed 12/15/23, instructed staff to reposition off coccyx (area at the base of the spine) every three to four hours due to pressure wound. Check and change the resident, provide an air mattress on the bed and a wheelchair cushion when R4 was in her wheelchair. On 01/15/24, the physician instructed staff to cleanse the coccyx wound with wound cleanser, apply skin prep to the peri wound (area around the wound) area and cover with a foam sacral (large triangular bone/area between the two hip bones at the base of the spine) dressing daily and as needed. A Skin/Wound Condition Assessment, dated 01/15/24, assessed the resident's stage three pressure ulcer measurements as one by one centimeter (cm) with a depth of 0.1 cm. Observation, on 01/24/24 at 08:15 AM, revealed the resident positioned in bed. Licensed Nurse LN H and Certified Nurse Aide (CNA) N dressed the resident and transferred her to her wheelchair. Observation on 01/24/24 at, 09:45 AM revealed the resident seated in a recliner in the common living area. Observations on 01/24/24 continued every fifteen minutes with the resident remaining in the recliner in the common living area. Observation, on 01/24/24 at 12:15 PM, (two and a half hours after seated in the recliner) revealed CNA O transferred the resident from her recliner to her wheelchair. The recliner lacked a pressure relieving device and had two folded bath blankets in the seat of the chair. CNA O stated the resident did not have a cushion in her recliner and could voice to staff the need to toilet. CNA O stated the resident had a cushion in her wheelchair but did not know if she should have a cushion in the recliner. Observation, on 01/24/24 at 01:30 PM revealed the resident seated in the recliner in the common living area. The recliner lacked a cushion. Observation, on 01/24/24 at 04:00 PM, revealed CMA G and CNA P transferred the resident from the recliner to her wheelchair and took her to the toilet. The resident was incontinent of bowel and bladder. Interview, on 01/25/24 at 10:30 AM, with Consulting Hospice Nurse GG, revealed the resident should have a cushion in the recliner as staff could move the cushion from her wheelchair to the recliner when transferring the resident. Interview, on 01/25/24 at 1:00 PM, with Administrative Staff A, revealed she would expect staff to provide pressure relieving devices to the resident when seated in a recliner and would expect licensed nurses to add interventions such as adding the pressure relieving cushion to the resident's recliner to the care plan to ensure the resident received pressure relief when sitting in the recliner. The facility policy Electronic Care Plan revised 12/20, instructed staff the person-centered plan of care reflects the care needs and voice of the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to revise this resident with a stage three pressure ulcer to include a pressure reducing device in her recliner to aid in healing her current pressure ulcer and prevention of further pressure ulcers.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 34 residents with 14 residents sampled, including two residents reviewed for Activities of Daily Living (ADL). Based on observation, interview and record review, the facility failed to provide facial grooming for one of the two sampled Residents (R)28 regarding the trimming of his beard and mustache. Findings included: - Review of Resident (R)28's electronic medical record (EMR) revealed the following diagnoses: Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and hemiplegia (paralysis on one side of the body). 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 required extensive assistance of two staff for personal hygiene and had an impairment in functional range of motion (ROM) on one side of his upper extremity. The Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 06/09/23, documented the resident had very limited use of his left arm and required extensive assistance of two staff for ADLs. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of five, indicating severe cognitive impairment. He was dependent on staff for personal hygiene needs. The care plan for ADLs, revised 10/10/23, instructed staff the resident was dependent on two staff for personal hygiene cares. Review of the resident's EMR from 12/26/23 through 01/23/24 revealed the resident was dependent on staff for personal hygiene needs, including shaving. On 01/23/24 at 10:57 AM, the resident sat in the recliner in his room. The resident had a beard and mustache which was long and unkempt which curled over his lips and into his mouth area. On 01/24/24 at 08:22 AM, the resident's beard and mustache continued to be long and unkempt, curling over his lips and into his mouth area. On 01/24/24 at 08:22 AM, Certified Nurse Aide (CNA)/hospitality aide, M stated she had not offered to trim the resident's beard and mustache. On 01/24/24 at 01:08 PM, CNA N confirmed the resident's facial hair was too long and stated she had not offered to trim the resident's facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/24 at 02:46 PM, Certified Medication Aide (CMA) R stated the resident did not refuse cares. CMA R was unsure of when the resident was to have his beard and mustache trimmed, but confirmed the resident was in need of a trim of his facial hair. On 01/25/24 at 01:29 PM, Administrative Staff A stated she would expect staff to ensure resident's facial hair was groomed appropriately. The facility lacked a policy regarding resident ADLs. The facility failed to provide this dependent resident with necessary personal hygiene assistance regarding trimming his facial hair.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 34 residents with 14 selected for review which included two residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation interview and record review, the facility failed to provide sanitary dressing change for one Resident (R)1 pressure ulcer and failed to implement pressure relieving device in R4's recliner. Findings included: - Review of Resident (R)1's Physician Order Sheet, dated 01/02/24, revealed diagnoses that included neuromuscular dysfunction of bladder (neurogenic bladder: the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), muscle weakness, arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement) and neuralgia (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The resident required substantial/maximal assistance with bed mobility. The resident was at risk for pressure ulcer development and had a pressure reducing device for chair and bed. The Pressure Ulcer Care Area Assessment (CAA), dated 07/19/23, assessed the resident needed extensive assistance with activities of daily living and staff monitored skin and used protective ointment to left foot and a protective boot. The Quarterly MDS, dated [DATE], assessed the resident with a BIMS score of 12 which indicated moderate cognitive impairment. The resident had no pressure ulcers but had moisture associated skin damage (inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous). The resident had a pressure relieving device for the chair, bed and received a turning and repositioning program. The Care Plan reviewed 12/29/23, instructed staff to check and change the resident as needed. An entry dated 12/17/23, instructed staff to provide dressing changes to the wounds on her left buttocks and coccyx (area at the base of the spine) as ordered. On 01/03/24, the physician instructed staff to cleanse the wound with wound cleanser, apply skin prep to the peri wound, apply Santyl (a prescription enzyme used to help break up and remove dead skin and tissue of a wound), cover with a collagen (protein derived wound treatment used to promote wound healing) pad and cover with a dressing, change daily and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 01/24/23 at 11:52 AM, revealed the resident positioned in bed. Licensed H removed a pillow from the resident's side, which contained a dried brown substance which LN H identified as vomit. Wound Consultant HH stated the resident's pressure ulcer as a stage three pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction in this case a full thickness pressure injury extending through the skin into the tissue below) and measured the wound as three by two centimeters (cm) with a 0.4 cm depth. Wound Consultant HH provided debridement (surgical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) at that time. Wound Consultant HH stated the wounds began from moisture associated skin damage caused by the resident's neurogenic bladder and the wounds improved after insertion of a urinary catheter and change in daily dressing change orders and now only one wound remained. The wound did become infected and was successfully treated with antibiotics. LN H cleansed the wound with wound cleanser, applied Santyl and covered the wound with calcium alginate and foam sacral dressing. Observation, on 01/25/24 at 10:58 AM, revealed the resident positioned in bed. Certified Nurse Aide (CNA) OO and (LN) I positioned the resident onto her left side for dressing change. The resident's bed linen contained wrinkles beneath her back and lower back. LN, I placed wound care supplied on a plastic bag on the residents over bed table without sanitizing the surface. LN J donned gloves and removed the soiled dressing which contained a large amount of tan drainage. With the same gloves LN, I cleansed the wound with wound cleanser, then with the same gloved hands proceeded to apply Santyl to the wound with a cotton tipped applicator. LN, I confirmed hand sanitization and gloving should occur after removing the old dressing, after cleansing the wound and before the application of the Santyl, collagen and final dressing to prevent the spread of infection. Interview, on 01/25/24 at 01:00 PM, with Administrative Staff A, revealed she would expect staff to provide dressing changes in a sanitary manner. The facility policy Wound Prevention and Management revised 12/2018, instructed staff to develop interventions to decrease the incidents of residents who develop pressure ulcers while providing guidelines for optimal care to promote healing for residents with all identified skin alterations. The Infection Management Process revised 11/2023, instructed staff to prevent and manage infection events. The facility failed to provide sanitary wound care, adjustments of linen to ensure decrease of pressure areas, and removal of soiled linen to prevent further infection in R1's stage three pressure ulcer to promote optimal wound healing. - Review of Resident (R)4's medical record, revealed diagnoses included heart failure, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) and muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8 which indicated severe cognitive impairment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Significant Change Minimum Data Set (MDS), dated [DATE], lacked assessment of the residents mental status and assessed the resident with two stage two pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction stage two partial thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) and one stage three pressure ulcer(full thickness pressure injury extending through the skin into the tissue below) present upon admission. The resident required substantial/maximum assistance with activities of daily living and transfers. The Pressure Ulcer Care Area Assessment (CAA) dated 12/15/23 assess the resident admitted with two stage two pressure ulcer and one stage three pressure ulcer on each buttock and coccyx (lower area of spine). The resident wore briefs for incontinence. The resident was able to reposition herself, but staff assisted the resident to turn and reposition every two hours and provide prompted toilet opportunity to the resident. The resident received hospice services. The Care Plan reviewed 12/15/23, instructed staff to reposition off coccyx (area at the base of the spine) every three to four hours due to pressure wound. Check and change the resident, provide an air mattress on the bed and a wheelchair cushion when R4 was in her wheelchair. On 01/15/24, the physician instructed staff to cleanse the coccyx wound with wound cleanser, apply skin prep to the peri wound (area around the wound) area and cover with a foam sacral (large triangular bone/area between the two hip bones at the base of the spine) dressing daily and as needed. A Skin/Wound Condition Assessment, dated 01/15/24, assessed the resident's stage three pressure ulcer measurements as one by one centimeter (cm) with a depth of 0.1 cm. Observation, on 01/24/24 at 08:15 AM, revealed the resident positioned in bed. Licensed Nurse LN H and Certified Nurse Aide (CNA)N removed the resident's urine saturated brief, which soaked through to the bed saver, and provided peri care. LN H removed the resident's dressing to her sacral area and cleansed the open pressure ulcer with wound cleanser, LN H stated she did not stage or measure wounds as the hospice nurse did this. The wound was approximately one centimeter in diameter, with yellow slough. LN H applied skin prep to the peri wound area and the applied a sacral foam dressing. CNA N and LN H dressed the resident and transferred her to her wheelchair. Observation on 01/24/24 at, 09:45 AM revealed the resident seated in a recliner in the common living area. Observations on 01/24/24 continued every fifteen minutes with the resident remaining in the recliner in the common living area. Observation, on 01/24/24 at 12:15 PM, (two and a half hours after seated in the recliner) revealed CNA O transferred the resident from her recliner to her wheelchair. The recliner lacked a pressure relieving device and had two folded bath blankets in the seat of the chair. CNA O transferred the resident onto the toilet and found the resident incontinent of stool and urine. CNA O provided peri care and then transferred the resident back into her wheelchair and took her to the dining room for noon meal. CNA O stated the resident did not have a cushion in her recliner and could voice to staff the need to toilet. CNA O stated the resident had a cushion in her wheelchair but did not know if she should have a cushion in the recliner. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 01/24/24 at 01:30 PM revealed the resident seated in the recliner in the common living area. The recliner lacked a cushion. Observation, on 01/24/24 at 04:00 PM, revealed CMA G and CNA P transferred the resident from the recliner to her wheelchair and took her to the toilet. The resident was incontinent of bowel and bladder. Interview, on 01/25/24 at 10:30 AM, with Consulting Hospice Nurse GG, revealed the resident should have a cushion in the recliner as staff could move the cushion from her wheelchair to the recliner when transferring the resident. Interview, on 01/25/24 at 1:00 PM, with Administrative Staff A, revealed she would expect staff to provide pressure relieving devices to the resident when seated in a recliner. The facility policy Wound Prevention and Management revised 12/2018, instructed staff to develop interventions to decrease the incidents of residents who develop pressure ulcers while providing guidelines for optimal care to promote healing for residents with all identified skin alterations. The facility failed to ensure staff provided this resident with a stage three pressure ulcer pressure relieving devices when seated in a recliner and adequate toileting routine to promote optimal wound healing.

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Medicalodges Iola	600 E Garfield Street Iola, KS 66749

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 34 residents with 14 residents sampled, including two residents reviewed for accidents. Based on interview, record review and observation, the facility failed to ensure one Resident (R)31 was kept free of accident hazards by failing to ensure her urinary catheter tubing (insertion of a catheter into the bladder to drain the urine into a collection bag) was contained to prevent a tripping hazard. Findings included: - Review of Resident (R)31's electronic medical record (EMR) revealed the following diagnoses: retention of urine (lack of ability to urinate and empty the bladder) and weakness. The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. She required substantial to maximal staff assistance to transfer from her bed to her wheelchair and partial to moderate staff assistance to go from lying to sitting on the side of her bed. She had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag), had one non-injury fall, and one injury (except major) fall since the prior assessment. The Functional Abilities Care Area Assessment (CAA), dated 01/03/24, documented the resident required extensive assistance of one staff with activities of daily living (ADL) and was non-ambulatory (unable to walk). The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of nine, indicating moderate cognitive impairment. She required substantial to maximal assistance of staff for transfers from her chair to her bed and partial to moderate assistance to go from lying to sitting on the side of her bed. She had an indwelling urinary catheter and had one non-injury fall since her prior assessment. The care plan for falls, revised 01/17/24, instructed staff to ensure the resident's catheter bag and tubing were not tangled. Staff were not to encourage the resident not to sit up on the side of the bed and were to ensure the resident had on non-skid socks or shoes on while ambulating or transferring. Review of the resident's EMR revealed fall assessments which placed the resident at a high risk for falls on 06/27/23, 09/15/23, 11/12/23 and 12/03/23. Review of the resident's EMR revealed an injury fall in the resident's room on 11/12/23. The resident's feet had become tangled in the tubing of her urinary catheter and when she attempted to free herself from the tubing, she fell the rest of the way out of the bed onto the fall mat next to her bed. The resident received a skin tear to her right arm and a bruise to her right shoulder. Staff treated the skin tear per facility protocol and the area healed without incident. The intervention for the fall was to ensure the catheter bag and tubing was placed where it was less likely for the resident to become tangled in the tubing if she were to attempt to get up on her own. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/24 at 12:55 PM, the resident propelled herself from the dining room to her room, using her feet, in her wheel chair. Certified Nurse Aide (CNA) N and CNA/Hospitality Aide M assisted the resident to transfer from her wheelchair to her bed to rest using extensive assistance of both staff and the use of a gait belt. The resident wore non-skid socks during the transfer. The catheter bag was hung on the bed frame with the tubing loose on the floor where the resident would place her feet if she attempted to sit up to the side of the bed, causing a fall hazard. On 01/24/24 at 02:58 PM, the resident was sitting up on the side of her bed with the catheter tubing resting directly between her bare feet on the floor. The tubing was wrapped once around the resident's left ankle. Certified Medication Aide (CMA) R entered the resident's room upon this surveyor's request and removed the tubing from around the resident's ankle, and transferred the resident from the bed to the wheelchair and propelled her to the activity room. On 01/25/24 at 09:34 AM, the resident was partially out of her bed with her feet down on the floor and tangled in her catheter tubing. Licensed Nurse (LN) G entered the resident's room upon this surveyor's request and assisted the resident in untangling her feet from the tubing and assisted her legs back up into the bed. On 01/24/24 at 01:08 PM, CNA N stated the resident's fall interventions included keeping her bed in the lowest position, the fall mat next to her bed and not leaving her in her room alone while in her wheelchair. CNA N was not aware of the intervention to keep the resident's catheter tubing secured. On 01/24/24 at 02:46 PM, CMA R stated the resident was confused and could not remember to use her call light for assistance. CMA R confirmed the catheter tubing should be kept secured and it had not been. On 01/25/24 at 09:34 AM, LN G stated the resident could trip on the catheter tubing if it was not kept secured in the dignity bag. LN G confirmed the resident's feet had been tangled in the tubing when she entered the room. On 02/25/24 at 01:29 PM, Administrative Staff A stated staff were expected to use the fall interventions which were put into place to help prevent resident falls. The catheter tubing being around the resident's feet and legs was a fall hazard for this dependent resident. It was the expectation for staff to follow fall interventions to help to prevent a fall with major injury. The facility policy for Falls Management, revised 12/2022, included: The facility strives to minimize the risk for resident alls. If a resident was identified at risk the facility shall initiate interventions and include them in the resident's individualized plan of care. The facility failed to ensure the fall interventions were being practiced for this dependent resident with a history of falls.

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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** 28560 The facility reported a census of 34 residents with 14 selected for review which included three residents reviewed for urinary catheter. Based on observation, interview and record review, the facility failed to ensure proper catheter care with securing of the catheter for one Resident (R)1 of the three residents reviewed, to prevent urethral trauma. Findings included: - Review of Resident (R)1's Physician Order Sheet, dated 01/02/24, revealed diagnoses that included neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), muscle weakness, arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement) and neuralgia (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The resident required substantial/maximal assistance with toileting and was always incontinent of urine. The ADL (Activities of Daily Living) Functional /Rehabilitation Care Area Assessment (CAA), dated 07/19/23, assessed the resident required extensive assistance of one to two staff for toilet use and peri care. The Quarterly MDS, dated [DATE], assessed the resident with a BIMS score of 12 which indicated moderate cognitive impairment. The resident had no pressure ulcers but had moisture associated skin damage (inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous). The resident was always incontinent of urine. The Care Plan reviewed 12/29/23, instructed staff the resident had sensory unawareness of urinary incontinence and to check and change and provide peri care every two to three hours as needed. The Care Plan lacked an update for instruction of the care and treatment of this resident's urinary catheter. On 01/09/24, the physician order instructed staff to insert a urinary catheter for bladder drainage due to the resident's neurogenic bladder. Observation, on 01/24/23 at 09:50 AM, revealed the resident positioned in bed. Licensed Nurse H and Certified Nurse Aide OO repositioned the resident in her bed. The resident's urinary catheter bag was attached to the bed frame with the lower part of the bag directly on the floor. The anchoring device for the catheter was not attached to the resident as it was twisted and stuck to itself around the catheter tubing. CNA OO and LN H provided peri care to the resident and repositioned the resident onto her right side. LN H stated the resident should have an anchoring device on the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 01/24/24 at 2:24 PM revealed CNA PP, repositioned the resident so she could eat lunch. CNA PP placed a pillow under the resident's legs and repositioned the urinary catheter. The urinary catheter lacked an anchoring device. Observation, on 01/25/24 at 10:58 AM, revealed the resident positioned in bed. Certified Nurse Aide (CNA) OO and (LN) I positioned the resident onto her left side for dressing change. The resident's bed linen contained wrinkles beneath her back and lower back. The resident's urinary catheter had the same nonfunctional twisted anchoring device adhered to itself around the catheter tubing, and no functional anchoring device to secure the catheter to prevent dislodgement or tearing of the urethra (small tubular structure that drains urine from the bladder). Interview, on 01/25/24 at 12:29 PM, with Administrative Nurse D, confirmed the January 2024 Medication Administration Record/ Treatment Administration Record (MAR/TAR) and the Care Plan lacked instruction for care of the urinary catheter and would expect licensed staff to ensure documentation on the MAR/TAR and Care Plan. Interview, on 01/25/24 at 01:00 PM, with Administrative Staff A, revealed she would expect staff to provide catheter care as per the standard of practice. The facility lacked a policy for catheter care. The facility failed to provide an anchoring device for this resident's catheter to prevent dislodgement or urethra trauma.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 34056 The facility reported a census of 34 residents. Based on interview and record review the facility failed to complete an annual performance review at least once every 12 months for four of four Certified Nurse Aides (CNA) reviewed, CNA N, CNA P, CNA Q and CNA MM and one of one Certified Medication Aide (CMA) reviewed, CMA S. Findings included: - Review of these four Certified Nurse Aide (CNA) and one Certified Medication Aide (CMA) personnel files, revealed the following concerns: 1. CMA S, hired 05/01/22, lacked an annual performance review in her personnel file. 2. CNA P, hired 05/01/22, lacked an annual performance review in her personnel file. 3. CNA Q, hired 09/26/22, lacked an annual performance review in his personnel file. 4. CNA MM, hired 05/01/22, lacked an annual performance review in her personnel file. 5. CNA N, hired 05/01/22, lacked an annual performance review in her personnel file. The facility handbook, undated, included: Full-time and part-time employees shall receive formal, written evaluations on an annual basis within two weeks of the employee's anniversary date. On 01/25/24 at 01:29 PM, Administrative Staff A stated she was unsure as to why these employees did not have an annual evaluation completed. The facility failed to complete annual performance reviews for these four CNAs and one CMA who had been an employee for over one year.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34056 The facility reported a census of 34 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. Findings included: - During an initial tour on 01/24/24 at 07:53 AM, the following areas of concern were noted: 1. Six plastic cutting boards had deep grooves, making the boards unsanitizable. 2. One large cutting board was put away as clean but contained a large coffee stain. 3. A cabinet to store clean dishes had shelving paper which was stained brown in areas and had a build-up of dust along the edges of the cabinet. The cabinet also had multiple areas of a dried on food substance. 4. Six wire racks in one two-door reach-in refrigerator had the protective coating missing from the tips of the wire racks, making them unsanitizable. 5. The stationary can open had a build-up of a black, sticky substance around the point of the opener which goes into the can while opening. 6. An unopened cardboard box containing 1000 10 ounce (oz) styrofoam cups rested directly on the floor of the store room. The facility policy for Sanitation of Dining and Food Service Areas, undated, documented the dining services staff will uphold sanitation of the dining areas according to a thorough, written schedule. Staff will be held responsible for all cleaning tasks. On 01/25/24 at 10:50 AM, Administrative Staff A confirmed the above issues were of concern. 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 34 residents with 14 selected for review. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program with the failure to provide a sanitary room environment for Resident (R)1 and failed to provide sanitary drainage of urinary catheter for R31 to prevent cross contamination and infections. Findings included: - Review of Resident (R)1's Physician Order Sheet, dated 01/02/24, revealed diagnoses that included neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), muscle weakness, arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement) and neuralgia (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The resident required substantial/maximal assistance with bed mobility. The resident was at risk for pressure ulcer development and had a pressure reducing device for chair and bed. The Pressure Ulcer Care Area Assessment (CAA), dated 07/19/23, assessed the resident needed extensive assistance with activities of daily living and staff monitored skin and used protective ointment to left foot and a protective boot. The Quarterly MDS, dated [DATE], assessed the resident with a BIMS score of 12 which indicated moderate cognitive impairment. The resident had no pressure ulcers but had moisture associated skin damage (inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous). The resident had a pressure relieving device for chair, bed and turning and repositioning program. The Care Plan reviewed 12/29/23, instructed staff to check and change the resident as needed. An entry dated 12/17/23, instructed staff to provide dressing changes to the wounds on her left buttocks and coccyx (area at the base of the spine) as ordered. Observation, on 01/24/23 at 09:50 AM, revealed the resident positioned in bed. Licensed Nurse (LN) H stated the resident was on contact isolation for infection in the resident's wound. LN H removed a pillow from the resident's side, which contained a dried brown substance which LN H identified as vomit. The resident's room floor contained several areas of sticky substance, and several blankets were piled on the floor behind the biohazard trash and linen containers. A foam positioning wedge was laying directly on the floor. Several pillows were laying directly on the floor. Interview, on 01/24/24 at 10:37 AM, with housekeeping staff U, revealed housekeeping cleans isolation rooms every other day but did not know when R1 room was last cleaned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 01/25/24 at 01:00 PM, with Administrative Staff A, revealed she would expect staff to provide a sanitary environment for the residents. The undated facility policy Resident Room Cleaning instructed staff to provide daily cleaning to resident room. The facility failed to ensure staff provided a sanitary room environment for this resident to prevent the spread of infection. 34056 - Review of Resident (R)31's electronic medical record (EMR) revealed a diagnosis of retention of urine (lack of ability to urinate and empty the bladder). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. She had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 01/03/24, documented the resident had an indwelling urinary catheter due to urinary retention. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of nine, indicating moderate cognitive impairment. She had an indwelling urinary catheter and had one non-injury fall since her prior assessment. The care plan for urinary catheter, revised 01/17/24, instructed staff to provide catheter care every shift. Review of the resident's EMR revealed a physician's order which documented the resident had a urinary catheter due to retention of urine, on 11/27/23. On 01/24/24 at 12:55 PM, Certified Nurse Aide (CNA) N and CNA/Hospitality Aide M emptied the urine from the resident's catheter bag. CNA M obtained the used graduate (a plastic measuring device used to measure fluids) from the resident's bathroom with her bare hands and held it against her top as she waited to drain the urine from the resident's catheter bag. CNA M drained approximately 150 cubic centimeters (cc) of dark, yellow cloudy urine from the resident's catheter bag and reattached the nozzle to the port on the side of the catheter bag without cleansing it with an alcohol swab. CNA N removed the nozzle from the port, cleansed it with an alcohol swab and reconnected the nozzle to the port. CNA M then entered the restroom to pour the urine from the graduate into the toilet. While leaning over to pour the urine into the toilet the gait belt (belt used to help transfer or stabilize during activity) bumped up against the toilet multiple times. CNA M then rinsed the graduate in the sink, poured the water into the toilet, dried the inside of the graduate with a paper towel and her bare hand and placed the graduate on a paper towel on the back of the toilet. On 01/24/24 at 01:08 PM, CNA/Hospitality Aide M stated she should have worn a glove when she brought the graduate out of the bathroom and she should have cleansed the nozzle of the catheter tubing with an alcohol swab before reattaching it to the port of the catheter bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/24 at 02:46 PM, CNA N stated she had unhooked the nozzle from the catheter bag and cleansed it with an alcohol swab after it had already been reattached. CNA N stated the nozzle needed to be cleansed before reinserting into the bag after emptying urine. While handling dirty things, such as the graduate, staff needed to always wear gloves and not hold dirty objects against their clothing. The gait belts should not come into contact with the toilet at any times. On 01/25/24 at 01:29 PM, Administrative Staff A confirmed CNA M needed more education on infection control practices as she had not provided good catheter care to the resident. The facility lacked a policy for catheter care. The facility failed to properly provide catheter care for this dependent resident with a urinary catheter to prevent cross contamination and infections.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 34 residents with 14 selected for review, which included one resident reviewed for antibiotic use. Based on observation, interview and record review, the facility failed to ensure Resident (R)27 received an appropriate antibiotic, based on culture report. The facility failed to track and trend causative microorganisms for infections and use of appropriate antibiotics. Findings included: - Review of Resident (R)27's Physician Order Sheet, dated 01/02/24, revealed diagnoses that included rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), major depressive disorder (major mood disorder which causes persistent feelings pf sadness) and peripheral vascular disease (slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The resident was always continent of urine. The ADL (Activity of Daily Living) Functional/Rehabilitation Care Area Assessment (CAA), dated 03/01/23, assessed the resident required assistance on one person for ADLs. The Quarterly Minimum Data Set, dated dated dated [DATE], assessed the resident with a BIMS score of seven which indicated severe cognitive impairment. The resident was occasionally incontinent of urine. The Care Plan reviewed 11/08/23, instructed staff to monitor signs and symptoms of dehydration (when the body loses fluid without replacing it) which included concentrated urine, new onset of confusion, headache, fatigue, and weakness. A Nurse's Note, dated 12/05/23, indicated the resident had increased confusion. A family member requested a urinalysis. The nurse's failed to document if staff attempted to increase fluid consumption, assess temperature, or pain. On 12/06/23, the physician order instructed staff to administer Bactrim DS twice a day, for three days, for urinary tract infection. A culture report, dated 12/09/23, indicated no growth of bacteria in the resident's urine. Review of the Infection Surveillance Monthly Report (a report that documents infections in the facility by resident) for December 2023, revealed lack of identification of the causative microorganisms from culture reports. This report documented the resident had altered mental status and urinary complaints and received Bactrim DS for three days and the infection was resolved. The report did not indicate that a culture was done or the results of the culture. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Infection Surveillance Monthly Report from February 2023 through December 2023, lacked identification of any causative microorganisms from culture reports if done. The January 2024 ongoing log was not available. Interview, on 01/25/24 at 01:00 PM, with Administrative Staff A, revealed infections were discussed in the QUAPI (Quality Assurance Performance Improvement) meetings with the Medical Director. The facility policy Infection Control Surveillance revised 11/2023, instructed the Infection Preventionist or designee to review the clinical record for diagnostic or lab results which support the use of the current antibiotic prescribed. The facility failed to identify causative organisms for infections on the Infection Surveillance Monthly Report to determine appropriate antibiotic usage, to identify trends and determine interventions to prevent the spread of infections as required.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 34056 The resident reported a census of 34 residents. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff in the facility kitchen. Findings included: - During the initial tour of the kitchen on 01/24/24 at 07:53 AM, the following area of concern was noted: The parameter of the floor and the floor where the table legs rested had a heavy build-up of dirt, trash, and discolored grime. On 01/25/24 at 10:50 AM, Administrative Staff A confirmed the areas of concern. The facility policy for Sanitation of Dining and Food Service Areas, undated, documented the dining services staff will uphold sanitation of the dining areas according to a thorough, written schedule. Staff will be held responsible for all cleaning tasks. The facility failed to provide a safe, functional, sanitary, and comfortable environment for staff and residents in the facility kitchen.