STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E637	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solomon Valley Manor	315 S Ash Street Stockton, KS 67669

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 29 residents. The sample included 12 residents of which one resident was reviewed for hospitalization s. Based on observation, record review, and interview, the facility failed to provide Resident (R) 28 with a bed hold policy as required. This placed the resident at risk of being unable to return to the facility in the same room or bed. Findings included: - R28's Electronic Medical Record (EMR) included diagnoses of anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), major depressive disorder (major mood disorder that causes persistent feelings of sadness), heart failure, disorder of bone, localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), acute kidney failure, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and bradycardia (low heart rate, less than 60 beats per minute). The Minimum Data Set (MDS) dated [DATE], documented R28 discharged from the facility with a return anticipated. The MDS, dated [DATE], documented an entry into the facility. The MDS, dated [DATE], documented a discharge from the facility with a return anticipated. The Progress Note dated 02/07/24 at 08:57 AM, documented R28's blood pressure (BP) was elevated. The resident reported her right arm was weak and numb. Her pupils were equal in size, and she had no facial drooping. Staff notified the physician and family of the condition and sent R28 by ambulance to the emergency room for evaluation and treatment. The Progress Note dated 02/12/24, documented R28 returned to the facility from the hospital. The Progress Note dated 04/12/24 at 01:06 PM, documented the facility was notified by the physician's office that R28 would be admitted to the hospital overnight or through the weekend to receive intravenous (IV-administered directly into the bloodstream via a vein) antibiotic treatment for an infection in her chin. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 04/19/24 at 08:15 PM, documented R28 returned to the facility from the hospital. R28's clinical record lacked evidence the resident or their representative received a copy of the bed hold notice when R28 was sent to the hospital. Upon request, the facility was unable to provide evidence a bed hold notice was provided to R28 and/or her representative. On 10/23/24 at 09:22 AM, Administrative Staff A reported the residents are given a transfer bed hold policy when admitted to the facility, and the original was kept in the chart. Administrative Staff A stated the form explained the ten-day bed hold for Medicaid payer source and verified the resident or the resident's representative had not received one at the time of her discharges. The facility's Bed Hold Policy, dated 04/10/24, documented the facility must provide written information to the Resident and/or Resident Representative when transferring a resident to a hospital or allowing a resident to go on a therapeutic leave that specified the duration of the facility bed hold policy. The facility failed to provide R28 with a bed-hold policy which placed the resident at risk of being unable to return to the facility in the same room or bed.

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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 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** 37450 The facility had a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to review and revise Resident (R) 23's care plan with resident-centered intervention to prevent R23's falls and R24's care plan to prevent pressure ulcers. This placed R24 and R23 at risk for further falls and injuries related to uncommunicated care needs. Findings included: - R23's Electronic Medical Record (EMR) documented that R23 had diagnoses of a need for assistance with personal care, hyperproteinemia (abnormally high level of protein in the blood), hypertension (HTN-elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), insomnia (inability to sleep), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), dementia (a progressive mental disorder characterized by failing memory and confusion), a personal history of urinary tract infections, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and atherosclerosis (plaque build-up in the walls of arteries, causing them to thicken). The Significant Change Minimum Data Set (MDS) dated [DATE] recorded R23 had severe cognitive impairment, inattention, disorganized thinking continuously, physical behaviors and rejection of care one to three days during the look-back period, and other behavioral symptoms not directed toward others four to six days of the look-back period. R23 required partial to moderate assistance with eating, substantial to maximal assistance with dressing, personal hygiene, and bed mobility, and was dependent on toileting and transfers. The MDS further documented R23 was 61 inches tall and weighed 120 pounds (lbs.), weight loss or gain was negative or unknown, and R23 did not receive a therapeutic or mechanically altered diet. R23 had a 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) and a skin tear. R23 had a pressure-reducing device for the chair and bed and required pressure ulcer care. The MDS further documented R23 had a fall in the last month and had a fracture related to the fall. R23 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), an antibiotic (a class of medications used to treat infections) and an opioid (a class of medications used to treat pain). The Fall Care Area Assessment (CAA), dated 09/11/24, documented R23 had a fall with a major injury on 09/01/24 and fractured her hip. R23 had a fall previously on 08/10/24 resulting in pelvic and rib fractures. R23 risks included confusion, one to two falls in the past three months, incontinence, balance difficulty (non-weight bearing status), use of wheelchair, medications, and diagnoses. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Care Plan dated 06/26/24, documented R23 had a fall in the past six months at the previous facility and was a high risk for falls. R23 had intermittent confusion, was ambulatory, had poor balance and gait and required the use of a wheeled walker (frequently forgot to use it). R23 was incontinent. The plan directed staff to encourage and assist R23 to keep the walker with her when ambulating, as she often forgot to bring it with her. The plan directed that if a fall occurred, alert the nurse to assess for injury and determine and put interventions in place to prevent further falls. On 06/28/24 the care plan was updated to include staff were to encourage R23 to wear non-slip footwear when ambulating or transferring. The Fall Care Plan dated 09/19/24, documented R23 was non-weight bearing due to a left hip fracture, used a wheelchair for locomotion propelled by staff. R23's Care Plan dated 09/19/24, directed staff to lower the bed to the floor and place a rolled blanket or body pillow under the bottom sheet on the outer aspect of the bed to help define the edge of the bed. The Progress Note dated 06/08/24 at 09:00 PM, documented R23 went to bed shortly after 06:00 PM, reporting she was worn out and tired. When staff went to get her ready for bed, R23 was in the bathroom without her walker, and staff reminded her that she is to use the walker when she got up. The Progress Note dated 07/28/24 at 02:35 PM, documented R23 was found on her bathroom floor at 01:00 PM, lying on her left side and holding her right side rib area. Staff notified R23's representative and physician of the fall and sent R23 to the hospital by ambulance to be evaluated. The facility was unable to provide an investigation to identify causative factors for the 07/28/24 fall. The Progress Note dated 08/11/24 at 01:59 AM, documented R23 had an unwitnessed fall around 09:30 PM on 0810/24, with injuries noted during the skin assessment. Staff called the hospital to see if the physician needed to see R23 due to the noted fractures at that time. The physician's response was to monitor R23 for any increase in pain or uncontrolled pain and if any were observed, send R23 to the hospital. The facility was unable to provide an investigation to identify causative factors for the 08/11/24 fall. R23's Care Plan lacked intervention to prevent further falls. The Progress Note dated 09/01/24 at 07:42 PM, documented at approximately 07:15 PM, staff alerted the nurse that R23 was lying on her left side on the floor with her head against the door jamb of the bathroom. The walker, along with a water cup, was tipped over and there was no water under R23's feet. R23 had severe pain and was grasping her left hip and thigh area. Staff called Emergency Medical Services (EMS) and R23 was transferred to the hospital. The facility was unable to provide an investigation to identify causative factors for the 09/01/24 fall. The Progress Note dated 09/01/24 at 09:57 PM, documented the facility nurse received correspondence from the hospital that R23 had a non-surgical fracture to her hip and would stay in the hospital for a few days for pain management. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 09/01/24, documented R23 had a laceration on her head that required three staples to close it. The Progress Note dated 09/05/24 at 03:30 PM, documented R23 had returned to the facility via EMS and was uncomfortable when repositioned. R23 had a large dark purple bruise to the left inner thigh, a skin tear to the left arm and a staple to the back of her head. R23 was non-weight bearing, had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag), and a urinary tract infection. The Progress Note dated 09/19/24, documented that R23 had a significant change due to a left hip fracture. She was non-weight bearing, required significant total assistance with self-care and mobility, and had uncontrolled pain on admission. R23 transferred using a mechanical lift, used a wheelchair for mobility propelled by staff, had a urinary tract infection, and several medication changes. The Progress Note dated 10/03/24 at 04:38 AM, documented the nurse checked R23's camera and noted she was not in her bed. The nurse found R23 in her recliner. Staff offered her the bathroom and R23 stated she had to go. R23 refused to let staff put her in a wheelchair, began screaming, and became combative. R23 had been incontinent of bowel, so she was gingerly ambulated to the bathroom where the staff was able to clean R23. Staff was then able to sit on her walker and transferred to her bed without difficulty. On 10/23/24 at 08:12 AM, observation revealed R23 in bed, bed in a low position. There was a black mat on the floor next to the bed, an air mattress on the bed, and there was no rolled pillow under the sheet. A camera faced the direction of her bed. On 10/24/23 at 08:10 AM, Certified Nurse Aide (CNA) M reported staff checked on the resident frequently. CNA M said R23 had a camera in the room so she could be visualized at the nurse's desk to prevent falls. On 10/24/24 at 08:15 AM, Licensed Nurse (LN) I stated the staff do frequent visual checks on R23. LN I confirmed R23 had a camera in the room to prevent falls. On 10/24/24 at 08:19 AM, Administrative Nurse E reported the staff nurses should update the care plan in the Activities of Living (ADL) book after each fall. Administrative Nurse E stated at the MDS interval, she tried to get the care plan updated in the EMR. Administrative Nurse E reported the nurses did the initial fall report and Administrative Nurse D did a further investigation for the root cause of the fall. On 10/24/24 at 08:27 AM, Administrative Nurse D stated the nurses fill out a fall investigation and are to include interventions to prevent further falls, which should be transferred to the ADL book and the EMR. Administrative Nurse D said that staff were instructed to check R23 more frequently with rounds at night shift, but this had not been added to the care plan. Administrative Nurse D verified a lack of fall interventions for R23's falls. (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's Plan of Care policy dated 04/10/24, documented it is the policy of the facility that a plan of care be developed and maintained for each resident. The plan of care is a working tool that provides a profile of the needs of the individual resident, identifies the role of each service in meeting these needs, and the supportive measures each service will use to complement each other in accomplishing the overall goal of care. The plan of care shall be reviewed as necessary, but at least quarterly. The resident and/or the representative will be informed of the review date and encouraged to participate in the review. The facility failed to update R23's Care Plan with new interventions to prevent further falls, which placed the resident at risk for further injuries due to uncommunicated care needs. - R24's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (HTN-elevated blood pressure), heart failure, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), bradycardia (low heart rate, less than 60 beats per minute), fracture of the right femur (thigh bone), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R24 had severe cognitive impairment and verbal behaviors directed toward others which occurred one to three days of the lookback period. R24 had functional range of motion impairment of one side lower extremity, required substantial/maximal assistance with toileting, dressing, and transfers. R24 had occasional incontinence of urine. R24 received scheduled, as-needed, and non-medication interventions for pain. The MDS further documented no falls since the prior assessment or readmit. The MDS documented R24 had recent surgery to repair a fracture of the pelvis, hip, leg, knee, or ankle. R24 had a surgical wound and wound care. R24 received an antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), diuretic (medication to promote the formation and excretion of urine), and opioid (a class of medication to treat pain). R24's Fall Care Plan dated 09/18/24, documented that R24 was admitted to the facility with a distal femur (thigh bone) fracture sustained from a fall before admission. R24 was a high risk for falls, required assistance with elimination, used a wheelchair, had numerous falls since admission during self-transfers, and did not remember she was unable to transfer independently. R24 was weight-bearing as tolerated due to a right hip fracture on 07/29/24. The care plan directed staff to ensure R24 had gripper socks or shoes on at all times when awake, ensure the call light was within reach, and ensure the video monitor was in place and turned on while R24 was in the room. The care plan further documented that if R24 was restless when in bed, offer and assist her to a recliner in the living room area. The Progress Note dated 02/12/24 at 04:01 PM, documented R24 admitted to the facility following a fall and fracture of her right hip at the previous facility which required surgical repair. R24 had a history of attempting to get out of bed to ambulate independently and a video monitor would be placed in the room. R24 would like to be as independent as possible. She had numerous falls since admission during self-transfers and did not remember she was unable to transfer independently or get up and walk independently> R24 needed to be reminded that it was unsafe for her to ambulate independently. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 02/13/24 at 01:52 AM, documented R24 had a fall around 09:43 PM on 02/12/24. After going to bed, the staff were not able to observe R24 with the video monitor. Upon checking, staff found R24 sitting on a pillow, on the floor in front of her recliner. R24 reported she thought a family member was coming to see her, so she wanted to get up. R24 denied pain or injury. R24's clinical record lacked evidence a fall investigation was completed, and interventions implemented to prevent further falls after the 02/12/24. The Progress Note dated 03/09/24, documented on 03/05/24 at approximately 05:45 PM, a resident notified staff that R24 fell in her bathroom. R24 was found on the floor of the bathroom with the wheelchair to the left of the resident and wheels locked in place. R24 had a tennis shoe on the left foot and a gripper sock with a leg brace on the right foot. R24 reported she was trying to go to the bathroom. R24 reported her right leg was sore, but said it was sore all week. The note documented the fall intervention was for staff to assist R24 to the bathroom when finished with supper. R24's clinical record lacked evidence a fall investigation was completed falls after the 03/05/24. The Progress Note dated 03/11/24 at 01:15 PM, staff reported nursing R24 sitting on the floor in the hallway and the wheelchair was in the bathroom. R24 had been toileted after lunch and denied injury. The note documented R24 would be care planned not to be left alone in the wheelchair. The Fall Investigation Report/Root Cause Analysis dated 03/18/24, documented an intervention to toilet R24 after all meals then to rest in recliner. Staff were alerted at the morning meeting to keep watch when meals were over for R24 heading to her bathroom. On 03/15/24 R23's Care Plan was updated with an intervention that directed staff to assist R24 to the bathroom on the way back from supper to prevent her from attempting to transfer herself into the bathroom. The Progress Note dated 03/18/24 at 07:10 PM, documented R24 was found sitting on the floor yelling Help me and for further information see fall paperwork. The Fall Investigation Report/Root Cause Analysis Report dated 03/20/24, documented R24 attempted to transfer self to toilet and to directed to continue current interventions and anticipate needs. The Progress Note dated 03/21/24 at 11:18 AM, documented the physician's response to the fall from the previous evening was to consider scheduled toileting, and the care plan directed staff to take R24 to the bathroom after each meal and to assist R24 to the recliner afterwards. R24 was reminded to always ask for help when needed to use the restroom. The Progress Note dated 04/27/24 at 06:18 PM, documented at 05:28 PM R24 was found sitting in front of closest on the floor, reported pain in the left knee, reporting she fell on her knee, no swelling or deformity. R24 reported she tried to transfer herself out of the wheelchair to get pajamas and fell . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Investigation Report/Root Cause Analysis dated 04/27/24, documented that R24 attempted a self-transfer, lost balance, and fell due to numbness and weakness in her legs. The intervention to prevent further falls was to set R23's pajamas out before supper so she could see them and not attempt to transfer herself. On 04/28/24 R23'sCare Plan was updated and directed staff to make sure to sit R24's in the bathroom where she could see them so she would not attempt to transfer herself and increase the risk of falls. The Progress Note dated 05/13/24, documented at 08:50 AM R24 had a non-injury fall and the incident report was completed. The Fall Investigation Report/Analysis Report dated 05/13/24, documented the cushion hung off the wheelchair and R24 slid to the floor. The intervention was to remove the cushion from the chair. The Progress Note dated 06/01/24 at 10:00 AM, documented that while at breakfast a visitor told staff R24 had fallen in the dining room. R24 had a bruise on her left hand from hitting it on her wheelchair. R24's family member stated the staff kept the wheelchair near her and locked so that when R24 attempted to transfer herself she had a stable chair to move to and would not slide out from underneath her. The Fall Report Form dated 06/01/24 documented that R24 fell in the dining room, had regular socks on, no gripper socks, the wheelchair was unlocked and was last toileted at 08:15 AM. Interventions were to place gripper socks on or put shoes on with regular socks. On 06/01/24 R23's Care Plan documented an intervention that directed staff to ensure R24 had gripper socks on when in bed or other non-slip footwear. This was a repeated intervention. The Progress Note dated 06/02/24 at 09:53 AM, documented at 09:33 AM, laundry personnel reported R24 had scooted out to the hallway on her buttocks trying to leave the room. No injuries were noted. The Fall Report Form dated 06/02/24 documented R24 sat in the hallway asking for help and stating she had tried to get up and fell , then scooted to the hallway. The intervention was to re-educate staff not to put R24 in a room by herself. The Progress Note dated 06/19/24 at 10:00 PM documented that R24 had an unwitnessed fall, was found sitting on the floor, and stated she had fallen out of her chair. The Fall Report Form dated 06/19/24, documented that several staff were present in the area of where R24 was sitting in a recliner and had a garbage can under the footrest, R24 crawled over the footrest and slid from the recliner to the floor. R24 was care planned as a one-person assist, gripper socks, unknown time of last toileted, and when not looking R24 reported she was trying to walk, and her legs got weak. The care plan was reviewed and updated to place gripper socks on and put shoes on with regular socks. The Progress Note dated 07/01/24 at 08:30 AM, documented that R24 fell to the floor in the dining room attempting to self-transfer and reported pain in her knees, which was not a new complaint. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Report Form dated 07/01/24 documented that R24 tried to move over to a wheelchair and fell in the dining room. The wheelchair brakes were unlocked and out of reach. The intervention was to anticipate R24's needs and assist to a wheelchair as soon as R24 was done eating. The Progress Note dated 07/25/24 at 02:02 PM, documented R24 sitting in front of a chair on the floor. R24 reported she was getting up to go to the bathroom and fell . R24 had edema from the hip down to her ankle, with external rotation and shortening of the right leg. The call light was within reach, gripper socks were on and the video monitor was on as planned. R24 sent to the hospital via Emergency Medical Services (EMS). The Progress Note dated 07/26/24 at 03:12 PM, documented that staff spoke to the hospital nurse and reported R24 planned for surgery that day and possible discharge to the facility the following Monday. The Progress Note dated 07/29/24 at 05:00 PM documented that R24 had returned from the hospital and reported pain to the right hip a ten of a scale of one to ten. The Progress Note dated 09/16/24 at 10:46 PM, documented staff assisted R24 to the bathroom and placed in the recliner. R24 was found sitting on the floor after the nurse checked on another resident. R24 reported she had to go to the bathroom. Staff had reminded R24 she had just been there and R24 reported she knew that but she needed to go again. The Fall Report Form dated 09/16/24 documented that R24 fell in the lounge area/nurses' station, had severe cognitive impairment, was wearing gripper socks, and had been toileted between 9:50 PM and 10:00 PM, R24 reported she had to use the bathroom. The root cause was that R24 had an urgent stool and got up independently for the bathroom because she did not know her limitations and the intervention to decrease the stool softener. On 10/23/24 at 11:00 AM observation revealed Licensed Nurse (LN) G walking R24 from her bathroom to a recliner in the living room area and close to the nurses' station. After a few minutes, R24 became restless and attempted to get out of the recline. R24 reported to LN D that she needed to go to the bathroom. LN G asked R24 to wait a few minutes for assistance and reminded R24 that she had just been to the bathroom. R24 stated she knew that but needed to go again. Another staff came by the area and took R24 to the bathroom. On 10/24/24 at 08:10 AM Certified Nurse Aide (CNA)M, stated staff checked on R24 frequently and had a video monitor in the room to prevent R24 from falling. On 10/24/24 at 08:15 AM, Licensed Nurse (LN) E stated the staff do frequent visual checks, kept R24 in the living room area and had a video monitor in the room to prevent falls. On 10/24/24 at 08:19 AM, Administrative Nurse E reported the staff nurses should update the care plan in the Activities of Living (ADL) book after each fall. Administrative Nurse E at the MDS interval tried to get the care plan updated in the EMR. Administrative Nurse E reported the nurses do the initial fall report and Administrative Nurse D a further investigation for the root cause of the fall. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 08:27 AM, Administrative Nurse D stated the nurses fill out a fall investigation and are to include interventions to prevent further falls, which should be transferred to the ADL book and the EMR. Administrative Nurse D verified lack of interventions for R24's falls. The facility's Plan of Care policy dated 04/10/24, documented it is the policy of the facility that a plan of care be developed and maintained for each resident. The plan of care is a working tool that provides a profile of the needs of the individual resident, identifies the role of each service in meeting these needs, and the supportive measures each service will use to complement each other in accomplishing the overall goal of care. The plan of care shall be reviewed as necessary, but at least quarterly. The resident and/or the representative will be informed of the review date and encouraged to participate in the review. The facility failed to update R24's care plan with new interventions to prevent further falls which placed the resident at risk for further injuries due to uncommunicated care needs.

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	17E637	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solomon Valley Manor	315 S Ash Street Stockton, KS 67669

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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 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** 37450 The facility had a census of 29 residents. The sample included 12 residents of which three were reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to provide interventions to prevent a facility-acquired pressure ulcer to Resident (R) 23's heel upon her significant change in mobility. The facility further failed to ensure all interventions were implemented as directed to prevent wound worsening or promote healing. This placed the resident at risk of complications related to skin breakdown and wounds. Findings included: - R23's Electronic Medical Record (EMR) documented that R23 had diagnoses of a need for assistance with personal care, hyperproteinemia (abnormally high level of protein in the blood), hypertension (HTN-elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), insomnia (inability to sleep), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), dementia (a progressive mental disorder characterized by failing memory and confusion), a personal history of urinary tract infections, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and atherosclerosis (plaque build-up in the walls of arteries, causing them to thicken). The Significant Change Minimum Data Set (MDS) dated [DATE] recorded R23 had severe cognitive impairment, inattention, disorganized thinking continuously, physical behaviors and rejection of care for one to three days during the look-back period, and other behavioral symptoms not directed toward others four to six days of the look-back period. R23 required partial to moderate assistance with eating, substantial to maximal assistance with dressing, personal hygiene, and bed mobility, and was dependent on toileting and transfers. The MDS further documented R23 was 61 inches tall and weighed 120 pounds (lbs.), weight loss or gain was negative or unknown, and R23 did not receive a therapeutic or mechanically altered diet. R23 had a pressure ulcer and a skin tear. R23 had a pressure-reducing device for the chair and bed and required pressure ulcer care. The MDS further documented had a fall in the last month and had a fracture related to the fall. R23 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), an antibiotic (a class of medications used to treat infections) and an opioid (a class of medications used to treat pain). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Ulcer Care Area Assessment (CAA), dated 09/17/24, documented that R23 had a Stage 1 pressure ulcer (pressure wound which appears reddened, does not blanche, and may be painful but is not open) to her outer left ankle and a Stage 2 pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) to the left heel which was noted the first week of her return to the facility from the hospital. Foam boots were applied and Skin- prep (liquid skin protectant) to the areas to prevent the worsening of her wounds and further skin breakdown. R23 had the potential for friction and shearing when transferring, required assistance with mobility due to a left hip fracture, and her nutrition was probably inadequate. The CAA further documented that R23 had a pressure-reducing mattress and cushion for her wheelchair. R23's Care Plan dated 06/26/24, documented R23 did not have skin issues on admission and was at mild risk for pressure ulcers. She had impaired sensory due to dementia and expressive aphasia (a disorder that affects the ability to communicate). She was occasionally incontinent of urine, nutrition was probably inadequate, and she had the potential for friction and shearing when transferring. The plan further documented that R23 would have a pressure-reducing mattress on her bed. The plan directed staff to prompt and assist R23 to use the toilet upon rising, every two to three hours while awake, at bedtime, at midnight, and 04:00 AM, and provide as-needed incontinent care to prevent skin breakdown. The plan further documented a nurse would assess R23's skin for bruising, redness, and open areas weekly and as needed, and during care staff to observe for skin changes; if any skin issues were noted the nurse would notify the physician and initiate appropriate interventions. R23's Physician Order dated 10/14/24, directed staff to cleanse the open area to the left heel with wound cleanser, pat dry, apply collagen (protein-derived wound treatment used to promote wound healing) to the area and cover with foam border dressing, and secure with tape if needed until resolved. The orders further directed staff to float heels with a pillow at all times while in bed and place a pillow behind the lower legs while in a wheelchair to prevent pressure to the left heel until the pressure sore was healed. The Progress Note dated 09/09/24 at 11:15 PM, noted the physician had been notified that R23 had a red spot to the outer left ankle and a blister area to the left heel, with treatment of Skin-prep to the areas until resolved. R23 was to wear foam boots to prevent further breakdown and the physician agreed with the plan and treatment. The Progress Note dated 09/10/24 at 02:30 PM, documented that R23 was six days following return from the hospital and was placed on an air mattress to prevent further breakdown to her coccyx (area at the base of the spine) area. The blister to the left heel was intact, Skin-prep was applied. The Progress Note dated 09/15/24 at 10:55 PM, documented R23's blister to the left heel to be open and the skin had pulled away, the area measured four centimeters (cm) in length and width. The area was cleansed and patted dry. Vaseline gauze and Telfa (nonstick gauze) dressings were applied to the area. The note further documented that the gel cushion sock was too tight and was left off to allow the foam boot to be put on. A fax was sent to the physician for notification and treatment was applied to the treatment record until a response was received. The Skin Evaluation Note dated 09/19/24, documented an opened blister to the left heel, with granulation (new tissue formed during wound healing) and sanguineous (bloody drainage) exudate (drainage). The dressing was saturated and the tissue was painful. The evaluation also included an open area to the coccyx. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skin Evaluation Note dated 10/03/24, documented the left heel wound measured 2 cm in width and length, had minimal drainage, was cleansed well, and a foam-bordered dressing was applied to both areas. R23 had gel heel protectors on and continued with a pressure wound to the coccyx. The Skin Evaluation Note dated 10/10/24, documented a left heel area of 1.8 cm in length x 1.4 cm in width with granulation, serous drainage, and peri-wound (surrounding skin) skin fragile. R23 continued with a pressure wound to her coccyx which measured 1.5 cm in length and 0.2 cm in width. The Skin Evaluation Note dated 10/17/24, documented a dried blister open ulcer to the left heel measuring 1. 5 cm in length, 1.5 cm in width, and 0.2 cm in depth. It had granulation tissue and serosanguineous drainage, which may have occurred due to treatment with collagen. The Skin Evaluation Note dated 10/18/24 documented the coccyx wound measured 1.2 cm in length, 0.2 cm in width, and 0.1 cm in depth; it had granulation. On 10/23/24 at 12:26 PM, observation revealed Certified Nurse Aide (CNA) M and CNA N providing grooming and transfer assistance for the midday meal and reported R23 would become physically aggressive until she was ready for help. Licensed Nurse (LN) H was also present for a dressing change to the coccyx area. The coccyx area was visualized and was no longer open. LN H reported the heel dressing was changed by the night shift nurse. Further observation revealed R23 had an air mattress on her bed. On 10/23/24 at 03:30 PM, observation revealed R23 sat in the living room commons area, in a wheelchair with a cushion on the seat. Her right leg was crossed over the left leg, and there was no pillow behind her legs on the wheelchair pedals. R23 was restless, folding and unfolding a blanket with a doll and moving and pulling at the lift straps. On 10/24/24 at 08:15 AM, LN E stated R23 required repositioning every two to three hours. LN E said R23 had an air mattress on the bed and had foam protective boots, but the boots did not seem to help so staff just floated R23's heels off the bed with pillows. On 10/24/24 at 08:27 AM, Administrative Nurse D verified that R23's plan of care had not been updated with interventions used to heal and prevent further skin breakdown. Administrative Nurse D stated that R23's heels should have been floated on pillows or used foam boots and was unsure when this was implemented. The facility's Prevention of Pressure Ulcers policy, dated 04/10/24, documented it was the policy of the facility to prevent and manage pressure ulcers to preserve or attain the highest level of skin integrity for all residents. All residents will be assessed by a licensed nurse for the risk potential of skin breakdown upon admission and quarterly. Those with high risk will be assessed every week by nursing in addition to taking preventative measures. The care plan team will develop individualized care plans implemented by the interdisciplinary team through the education of staff. The facility failed to provide interventions to prevent a facility-acquired pressure ulcer to R23's heel upon her significant change in mobility. The facility further failed to ensure all interventions were implemented as directed to prevent worsening or promote healing. This placed the resident at risk of complications related to skin breakdown and wounds.

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F 0689 Level of Harm - 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** 37450 The facility had a census of 29 residents, with 12 sampled, including six reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision and identify and implement interventions to prevent falls for Resident (R) 24 and R23, who had falls resulting in major injuries. This placed the residents at the risk of ongoing falls and injuries. Findings included: - R23's Electronic Medical Record (EMR) documented R23 had diagnoses of a need for assistance with personal care, hyperproteinemia (abnormally high level of protein in the blood), hypertension (HTN-elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), insomnia (inability to sleep), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), dementia (a progressive mental disorder characterized by failing memory and confusion), a personal history of urinary tract infections, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and atherosclerosis (plaque build-up in the walls of arteries, causing them to thicken). The Significant Change Minimum Data Set (MDS) dated [DATE] recorded R23 had severe cognitive impairment, inattention, disorganized thinking continuously, physical behaviors and rejection of care for one to three days during the look-back period, and other behavioral symptoms not directed toward others four to six days of the look-back period. R23 required partial to moderate assistance with eating, substantial to maximal assistance with dressing, personal hygiene, and bed mobility, and was dependent on toileting and transfers. The MDS further documented R23 was 61 inches tall and weighed 120 pounds (lbs.), weight loss or gain was negative or unknown, and R23 did not receive a therapeutic or mechanically altered diet. R23 had a 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) and a skin tear. R23 had a pressure-reducing device for the chair and bed and required pressure ulcer care. The MDS further documented R23 had a fall in the last month and had a fracture related to the fall. R23 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), an antibiotic (a class of medications used to treat infections) and an opioid (a class of medications used to treat pain). The Fall Care Area Assessment (CAA), dated 09/11/24, documented R23 had a fall with a major injury on 09/01/24 and fractured her hip. R23 had a fall previously on 08/10/24 resulting in pelvic and rib fractures. R23 risks included confusion, one to two falls in the past three months, incontinence, balance difficulty (non-weight bearing status), use of wheelchair, medications, and diagnoses. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Care Plan dated 06/26/24, documented R23 had a fall in the past six months at the previous facility and was a high risk for falls. R23 had intermittent confusion, was ambulatory, had poor balance and gait, and required the use of a wheeled walker (frequently forgot to use it). R23 was incontinent. The plan directed staff to encourage and assist R23 to keep the walker with her when ambulating, as she often forgot to bring it with her. The plan directed that if a fall occurred, alert the nurse to assess for injury and determine and put interventions in place to prevent further falls. On 06/28/24 the care plan was updated to include staff were to encourage R23 to wear non-slip footwear when ambulating or transferring. The Fall Care Plan dated 09/19/24, documented R23 was non-weight bearing due to a left hip fracture and used a wheelchair for locomotion propelled by staff. R23's Care Plan dated 09/19/24, directed staff to lower the bed to the floor and place a rolled blanket or body pillow under the bottom sheet on the outer aspect of the bed to help define the edge of the bed. The Progress Note dated 06/08/24 at 09:00 PM, documented R23 went to bed shortly after 06:00 PM, reporting she was worn out and tired. When the staff went to get her ready for bed, R23 was in the bathroom without her walker, and the staff reminded her that she was to use the walker when she got up. The Progress Note dated 07/28/24 at 02:35 PM, documented R23 was found on her bathroom floor at 01:00 PM, lying on her left side and holding her right side rib area. Staff notified R23's representative and physician of the fall and sent R23 to the hospital by ambulance to be evaluated. The facility was unable to provide an investigation to identify causative factors for the 07/28/24 fall. The Progress Note dated 08/11/24 at 01:59 AM, documented R23 had an unwitnessed fall around 09:30 PM on 0810/24, with injuries noted during the skin assessment. Staff called the hospital to see if the physician needed to see R23 due to the noted fractures at that time. The physician's response was to monitor R23 for any increase in pain or uncontrolled pain and if any were observed, send R23 to the hospital. The facility was unable to provide an investigation to identify causative factors for the 08/11/24 fall. R23's Care Plan lacked intervention to prevent further falls. The Progress Note dated 09/01/24 at 07:42 PM, documented at approximately 07:15 PM, staff alerted the nurse that R23 was lying on her left side on the floor with her head against the door jamb of the bathroom. The walker, along with a water cup, was tipped over and there was no water under R23's feet. R23 had severe pain and was grasping her left hip and thigh area. Staff called Emergency Medical Services (EMS) and R23 was transferred to the hospital. The facility was unable to provide an investigation to identify causative factors for the 09/01/24 fall. The Progress Note dated 09/01/24 at 09:57 PM, documented the facility nurse received correspondence from the hospital that R23 had a non-surgical fracture to her hip and would stay in the hospital for a few days for pain management. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 09/01/24, documented R23 had a laceration on her head that required three staples to close it. The Progress Note dated 09/05/24 at 03:30 PM, documented R23 had returned to the facility via EMS and was uncomfortable when repositioned. R23 had a large dark purple bruise to the left inner thigh, a skin tear to the left arm, and a staple to the back of her head. R23 was non-weight bearing, had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag), and had a urinary tract infection. The Progress Note dated 09/19/24, documented that R23 had a significant change due to a left hip fracture. She was non-weight bearing, required significant total assistance with self-care and mobility, and had uncontrolled pain on admission. R23 transferred using a mechanical lift, used a wheelchair for mobility propelled by staff, had a urinary tract infection, and several medication changes. The Progress Note dated 10/03/24 at 04:38 AM, documented the nurse checked R23's camera and noted she was not in her bed. The nurse found R23 in her recliner. Staff offered her the bathroom and R23 stated she had to go. R23 refused to let staff put her in a wheelchair, began screaming, and became combative. R23 had been incontinent of bowel, so she was gingerly ambulated to the bathroom where the staff was able to clean R23. Staff was then able to sit on her walker and transferred to her bed without difficulty. On 10/23/24 at 08:12 AM, observation revealed R23 in bed, bed in a low position. There was a black mat on the floor next to the bed, an air mattress on the bed, and there was no rolled pillow under the sheet. A camera faced the direction of her bed. On 10/24/23 at 08:10 AM, Certified Nurse Aide (CNA) M reported staff checked on the resident frequently. CNA M said R23 had a camera in the room so she could be visualized at the nurse's desk to prevent falls. On 10/24/24 at 08:15 AM, Licensed Nurse (LN) I stated the staff do frequent visual checks on R23. LN I confirmed R23 had a camera in the room to prevent falls. On 10/24/24 at 08:19 AM, Administrative Nurse E reported the staff nurses should update the care plan in the Activities of Living (ADL) book after each fall. Administrative Nurse E stated at the MDS interval, she tried to get the care plan updated in the EMR. Administrative Nurse E reported the nurses did the initial fall report and Administrative Nurse D did a further investigation for the root cause of the fall. On 10/24/24 at 08:27 AM, Administrative Nurse D stated the nurses fill out a fall investigation and are to include interventions to prevent further falls, which should be transferred to the ADL book and the EMR. Administrative Nurse D said that staff were instructed to check R23 more frequently with rounds on the night shift, but this had not been added to the care plan. Administrative Nurse D verified a lack of fall interventions for R23's falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Falls (witnessed/unwitnessed) policy, dated 01/10/24, documented it was the policy of the facility that all falls, witnessed and unwitnessed, would be investigated and intervention put into place to attempt to prevent reoccurrence. The nurse will investigate why and how the fall occurred, review the care plan provide modifications, or put new interventions in place to prevent further falls from occurring. The facility failed to investigate falls for causative factors. The facility further failed to identify and implement interventions following falls to prevent further falls. As a result, R23 fell and fractured her hip resulting in impaired mobility. This also placed the resident at risk for increased pain and further falls. - R24's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (HTN-elevated blood pressure), heart failure, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), bradycardia (low heart rate, less than 60 beats per minute), fracture of the right femur (thigh bone), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R24 had severe cognitive impairment and verbal behaviors directed toward others which occurred one to three days of the observation period. R24 had a functional range of motion impairment of a lower extremity on one side and required substantial/maximal assistance with toileting, dressing, and transfers. R24 had occasional incontinence of urine. R24 received scheduled, as-needed, and non-medication interventions for pain. The MDS further documented no falls since the prior assessment or readmit. The MDS documented R24 had recent surgery to repair a fracture of the pelvis, hip, leg, knee, or ankle. R24 had a surgical wound and wound care. R24 received an antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), diuretic (medication to promote the formation and excretion of urine), and opioid (a class of medication to treat pain). R24's Fall Care Plan dated 09/18/24, documented that R24 was admitted to the facility with a distal femur (thigh bone) fracture sustained from a fall before admission. R24 was a high risk for falls, required assistance with elimination, used a wheelchair, had numerous falls since admission during self-transfers, and did not remember she was unable to transfer independently. R24 was weight-bearing as tolerated due to a right hip fracture on 07/29/24. The care plan directed staff to ensure R24 had gripper socks or shoes on at all times when awake, ensure the call light was within reach, and ensure the video monitor was in place and turned on while R24 was in the room. The care plan further documented that if R24 was restless when in bed, offer and assist her to a recliner in the living room area. The Progress Note dated 02/12/24 at 04:01 PM, documented R24 admitted to the facility following a fall and fracture of her right hip at the previous facility which required surgical repair. R24 had a history of attempting to get out of bed to ambulate independently and a video monitor would be placed in the room. R24 would like to be as independent as possible. She had numerous falls since admission during self-transfers and did not remember she was unable to transfer independently or get up and walk independently. R24 needed to be reminded that it was unsafe for her to ambulate independently. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 02/13/24 at 01:52 AM, documented R24 had a fall around 09:43 PM on 02/12/24. After going to bed, the staff were not able to observe R24 with the video monitor. Upon checking, staff found R24 sitting on a pillow, on the floor in front of her recliner. R24 reported she thought a family member was coming to see her, so she wanted to get up. R24 denied pain or injury. R24's clinical record lacked evidence a fall investigation was completed, and interventions were implemented to prevent further falls after the 02/12/24 fall. The Progress Note dated 03/09/24, documented on 03/05/24 at approximately 05:45 PM, a resident notified staff that R24 fell in her bathroom. R24 was found on the floor of the bathroom with the wheelchair to the left of the resident and wheels locked in place. R24 had a tennis shoe on the left foot and a gripper sock with a leg brace on the right foot. R24 reported she was trying to go to the bathroom. R24 reported her right leg was sore, but said it was sore all week. The note documented the fall intervention was for staff to assist R24 to the bathroom when finished with supper. R24's clinical record lacked evidence a fall investigation was completed after the 03/05/24 fall. The Progress Note dated 03/11/24 at 01:15 PM, staff reported nursing R24 sitting on the floor in the hallway and the wheelchair was in the bathroom. R24 had been toileted after lunch and denied injury. The note documented R24 would be care planned not to be left alone in the wheelchair. The Fall Investigation Report/Root Cause Analysis dated 03/18/24, documented an intervention to toilet R24 after all meals and then to rest in the recliner. Staff were alerted at the morning meeting to keep watch when meals were over for R24 heading to her bathroom. On 03/15/24 R24's Care Plan was updated with an intervention that directed staff to assist R24 to the bathroom on the way back from supper to prevent her from attempting to transfer herself into the bathroom. The Progress Note dated 03/18/24 at 07:10 PM, documented R24 was found sitting on the floor yelling Help me and for further information, see fall paperwork. The Fall Investigation Report/Root Cause Analysis Report dated 03/20/24, documented R24 attempted to transfer herself to the toilet, and staff were directed to continue current interventions and anticipate her needs. The Progress Note dated 03/21/24 at 11:18 AM, documented the physician's response to the fall from the previous evening was to consider scheduled toileting, and the care plan directed staff to take R24 to the bathroom after each meal and to assist R24 to the recliner afterward. R24 was reminded to always ask for help when needed to use the restroom. The Progress Note dated 04/27/24 at 06:18 PM, documented at 05:28 PM R24 was found sitting in front of closest on the floor, reported pain in the left knee, reporting she fell on her knee, no swelling or deformity. R24 reported she tried to transfer herself out of the wheelchair to get pajamas and fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Investigation Report/Root Cause Analysis dated 04/27/24, documented that R24 attempted a self-transfer, lost balance, and fell due to numbness and weakness in her legs. The intervention to prevent further falls was to set R24's pajamas out before supper so she could see them and not attempt to transfer herself. On 04/28/24 R24'sCare Plan was updated and directed staff to make sure to sit R24's in the bathroom where she could see them so she would not attempt to transfer herself and increase the risk of falls. The Progress Note dated 05/13/24, documented at 08:50 AM R24 had a non-injury fall and the incident report was completed. The Fall Investigation Report/Analysis Report dated 05/13/24, documented the cushion hung off the wheelchair and R24 slid to the floor. The intervention was to remove the cushion from the chair. The Progress Note dated 06/01/24 at 10:00 AM, documented that while at breakfast a visitor told staff R24 had fallen in the dining room. R24 had a bruise on her left hand from hitting it on her wheelchair. R24's family member stated the staff kept the wheelchair near her and locked it so that when R24 attempted to transfer herself she had a stable chair to move to and would not slide out from underneath her. The Fall Report Form dated 06/01/24 documented that R24 fell in the dining room, had regular socks on, no gripper socks, the wheelchair was unlocked, and was last toileted at 08:15 AM. Interventions were to place gripper socks on or put shoes on with regular socks. On 06/01/24 R24's Care Plan documented an intervention that directed staff to ensure R24 had gripper socks on when in bed or other non-slip footwear (this was already care planned). The Progress Note dated 06/02/24 at 09:53 AM, documented at 09:33 AM, laundry personnel reported R24 had scooted out to the hallway on her buttocks trying to leave the room. No injuries were noted. The Fall Report Form dated 06/02/24 documented R24 sat in the hallway asking for help and stating she had tried to get up and fell , then scooted to the hallway. The intervention was to re-educate staff not to put R24 in a room by herself. The Progress Note dated 06/19/24 at 10:00 PM documented that R24 had an unwitnessed fall, was found sitting on the floor, and stated she had fallen out of her chair. The Fall Report Form dated 06/19/24, documented that several staff were present in the area where R24 was sitting in a recliner and she had a garbage can under the footrest. R24 crawled over the footrest and slid from the recliner to the floor. R24 was care planned as a one-person assist, gripper socks, unknown time of last toileted. R24 reported she was trying to walk, and her legs got weak. The care plan was reviewed and updated to place gripper socks on and put shoes on with regular socks. The Progress Note dated 07/01/24 at 08:30 AM, documented that R24 fell to the floor in the dining room attempting to self-transfer and reported pain in her knees, which was not a new complaint. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solomon Valley Manor	315 S Ash Street Stockton, KS 67669

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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 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Report Form dated 07/01/24 documented that R24 tried to move over to a wheelchair and fell in the dining room. The wheelchair brakes were unlocked and out of reach. The intervention was to anticipate R24's needs and assist in a wheelchair as soon as R24 was done eating. The Progress Note dated 07/25/24 at 02:02 PM, documented R24 sitting in front of a chair on the floor. R24 reported she was getting up to go to the bathroom and fell . R24 had edema from the hip down to her ankle, with external rotation and shortening of the right leg. The call light was within reach, gripper socks were on and the video monitor was on as planned. R24 sent to the hospital via Emergency Medical Services (EMS). The Progress Note dated 07/26/24 at 03:12 PM, documented that staff spoke to the hospital nurse and reported R24 planned for surgery that day and possible discharge to the facility the following Monday. The Progress Note dated 07/29/24 at 05:00 PM documented that R24 had returned from the hospital and reported pain to the right hip a 10 on a scale of one to 10. The Progress Note dated 09/16/24 at 10:46 PM, documented staff assisted R24 to the bathroom and placed in the recliner. R24 was found sitting on the floor after the nurse checked on another resident. R24 reported she had to go to the bathroom. Staff had reminded R24 she had just been there and R24 reported she knew that but she needed to go again. The Fall Report Form dated 09/16/24 documented that R24 fell in the lounge area/nurses' station, had severe cognitive impairment, was wearing gripper socks, and had been toileted between 9:50 PM and 10:00 PM, R24 reported she had to use the bathroom. The root cause was that R24 had an urgent stool and got up independently for the bathroom because she did not know her limitations and the intervention to decrease the stool softener. On 10/23/24 at 11:00 AM observation revealed Licensed Nurse (LN) G walking R24 from her bathroom to a recliner in the living room area and close to the nurses' station. After a few minutes, R24 became restless and attempted to get out of the recline. R24 reported to LN D that she needed to go to the bathroom. LN G asked R24 to wait a few minutes for assistance and reminded R24 that she had just been to the bathroom. R24 stated she knew that but needed to go again. Another staff came by the area and took R24 to the bathroom. On 10/24/24 at 08:10 AM Certified Nurse Aide (CNA)M, stated staff checked on R24 frequently and had a video monitor in the room to prevent R24 from falling. On 10/24/24 at 08:15 AM, LN E stated the staff did frequent visual checks, kept R24 in the living room area and had a video monitor in the room to prevent falls. On 10/24/24 at 08:19 AM, Administrative Nurse E reported the staff nurses should update the care plan in the activities of living (ADL) book after each fall. Administrative Nurse E updated plans at the MDS interval and tried to get the care plan updated in the EMR. Administrative Nurse E reported the nurses did the initial fall report and Administrative Nurse D a further investigation for the root cause of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/24/24 at 08:27 AM, Administrative Nurse D stated the nurses fill out a fall investigation and are to include interventions to prevent further falls, which should be transferred to the ADL book and the EMR. Administrative Nurse D verified the lack of interventions for R24's falls. The facility's Falls (witnessed/unwitnessed) policy, dated 01/10/24, documented it was the policy of the facility that all falls, witnessed and unwitnessed, would be investigated and intervention put into place to attempt to prevent reoccurrence. The nurse will investigate why and how the fall occurred, review the care plan provide modifications, or put new interventions in place to prevent further falls from occurring. The facility failed to investigate and implement relevant interventions to prevent R24 from falling. This placed the resident at risk for further falls and injuries.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 29 residents. The sample included 12 residents with two residents reviewed for nutrition. Based on observation, record review, and interview, the facility failed to recognize Resident (R) 23's weight loss and act upon the Registered Dietician (RD) recommendation to prevent further loss. This resulted in a significant unintended weight loss of 9.74 percent in three months and placed the resident at risk for complications related to continued weight loss. Findings include: - R23's Electronic Medical Record (EMR) documented R23 had diagnoses of a need for assistance with personal care, hyperproteinemia (abnormally high level of protein in the blood), hypertension (HTN-elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), insomnia (inability to sleep), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), dementia (a progressive mental disorder characterized by failing memory and confusion), a personal history of urinary tract infections, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and atherosclerosis (plaque build-up in the walls of arteries, causing them to thicken). The Significant Change Minimum Data Set (MDS) dated [DATE] recorded R23 had severe cognitive impairment, inattention, disorganized thinking continuously, physical behaviors and rejection of care for one to three days during the observation period, and other behavioral symptoms not directed toward others four to six days of the observation period. R23 required partial to moderate assistance with eating, substantial to maximal assistance with dressing, personal hygiene, and bed mobility, and was dependent for toileting and transfers. The MDS further documented R23 was 61 inches tall and weighed 120 pounds (lbs.), weight loss or gain was negative or unknown, and R23 did not receive a therapeutic or mechanically altered diet. R23 had a 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) and a skin tear. R23 had a pressure-reducing device for the chair and bed and required pressure ulcer care. R23 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), an antibiotic (a class of medications used to treat infections) and an opioid (a class of medications used to treat pain). The Nutritional Status Care Area Assessment (CAA), dated 09/17/24, documented R23 ate well and could feed herself but may need her food cut up. R23 could no longer make choices and was not a picky eater. R23's initial admission weight was 132 lbs., and her current weight was 120 lbs. The CAA further documented R23 had severe dementia and required cues and assistance regarding mealtime and the location of the dining room. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R23's Nutrition Care Plan, dated 06/26/24, documented R23 received a regular diet, ate well, and fed herself but may need her food cut up. The plan recorded R23 liked coffee and juice at breakfast and soda at some meals. R23 made choices when asked, and weighed 132 lbs. The care plan directed staff to encourage R23 to feed herself but assist as needed; she may need cues or reminders, and her food cut up. The care plan further directed staff to offer a snack during snack pass. The Physician Order, dated 06/04/24, directed staff R23 to receive liberalized geriatric, regular textured, and thin-consistency liquids as tolerated. R23's orders contained no nutritional supplements. R23's EMR recorded R23's weight on 06/07/24 was 132 lbs. The RD Progress Note dated 06/30/24, documented R23's weight of 127 lbs. showed her weight was stable. Staff reported R23 was more independent at meals and her appetite had improved. The RD further noted observation of R23 at lunch revealed the resident eating independently without problems with chewing or swallowing, and trouble making her needs known. R23 received a liberalized geriatric regular diet with regular liquids. The note continued that if weight loss occurred, the RD recommended adding eight ounces (oz.) of house supplement or shake in the afternoon to meet the resident's estimated needs. R23's EMR recorded R23's weight on 07/03/14 was 131.4 lbs. On 08/07/24, R23 weighed 126 lbs. which indicated a 4.11 percent (%) weight loss in 35 days. R23's clinical record lacked evidence the facility implemented the eight-ounce nutritional supplement in response to the 4.11 % loss as recommended by the RD on 06/30/24. The RD Progress Note, dated 09/07/24, documented the RD was notified of a pressure ulcer to R23's left heel and coccyx (area at the base of the spine). R23 weighed 119.8 lbs. and had a 4.8 lb. loss in one month and a 12.2 lb. loss since admission. RD recommended four to eight oz. house supplement or shake with Pro-powder (protein supplement) in the afternoon, four oz. of Arginaid (a nonprescription nutritional drink that supplies the amino acid L-arginine along with vitamins C and E) twice a day at meals, multivitamin, and vitamin C 500 milligrams (mg) twice a day for healing and to prevent further weight loss. The note recorded a goal of no further weight loss and healing of R23's pressure ulcer to the heel and coccyx. R23's clinical record lacked evidence the facility implemented the nutritional interventions recommended by the RD on 09/07/24. The Progress Note dated 09/19/24 at 02:30 PM, documented R23's care conference was held with the Interdisciplinary Team (IDT). R23 had a significant change due to a fall with a left hip fracture. R23 required significant total assistance with self-care and mobility. R23 did and could feed herself and had significant weight loss. R23 was readmitted with a urinary tract infection and uncontrolled pain. R23's EMR recorded R23's weight on 10/02/24 was 118.6 lbs. which showed a significant loss of 9.74 % in three months. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 12:29 PM, observation revealed R23 sat in the dining room in a wheelchair eating lunch independently. Staff briefly sat at the table with the resident. On 10/23/24 at 11:34 AM, observation revealed R23 remained in bed. On 10/23/24 at 12:26 PM, observation revealed Certified Nurse Aide (CNA) N and CNA M got R23 out of bed. CNA N reported R23 slept in late and would refuse to let staff get her up. Staff reported that R23 exhibited physical and verbal behaviors if she did not want to get up, so they checked on her frequently to see when she wanted to get up. Once R23 was dressed and groomed, staff took R23 to the dining room, where she fed herself the meal. During an interview on 10/24/24 at 08:04 AM, Dietary Staff CC reported R23 had not been on the afternoon snack or supplement list. During an interview on 10/24/24 at 08:09 AM, Administrative Nurse E reported the dietary manager reviewed the RD recommendations and was to report recommendations to the nursing department to get orders from the physician. Administrative Nurse E was unaware of the RD recommendations to address R23's weight loss and wound healing. During an interview on 10/24/24 at 08:27 AM, Administrative Nurse D stated the dietary manager reviewed the RD recommendations and verified the recommendations for R23 should be implemented. During an interview on 10/24/24 at 12:00 PM, Dietary Staff BB reported she monitored the resident's weights weekly, to every two weeks. DS BB reported the dietary staff had some staff schedule and personnel changes and R23's RD recommendations slipped through the cracks. The facility's Weighing Residents policy, dated 04/10/24, documented the resident's weights were to be monitored for weight loss or gain. All new residents would be evaluated by the Registered Dietician at the next scheduled visits. Residents who develop concerns would be scheduled with the Registered Dietician for a re-evaluation at the next scheduled visit or sooner if warranted. Residents who showed an unplanned increase or loss greater than five pounds in one week would have their physician notified. The facility failed to recognize R23's weight loss and act upon the RD's recommendation to prevent further loss. This resulted in a significant unintended weight loss of 9.74 %. This also placed the resident at risk for complications related to the loss and continued weight loss.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 29 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to ensure the Consultant Pharmacist (CP) identified and reported that Resident (R)14 lacked a stop date as required by the Center for Medicare and Medicaid Services (CMS) for the continued use of as-needed (PRN) Ativan (antianxiety medication). This placed R14 at risk for complications related to psychotropic (alters mood or thought) medication use beyond 14 days. Findings included: - R14'sElectronic Medical Record documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and recurrent major depressive disorder (MDD- mood disorder which causes persistent feelings of sadness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R14 had short- and long-term memory problems with severely impaired decision-making. The MDS documented R14 had physical, verbal, and wandering behaviors and received antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and opioid medications (a class of controlled drugs used to treat pain). R14's Care Plan, dated 07/03/24, documented R14 was at risk for adverse behaviors related to diagnoses of dementia and anxiety. R14 has noted anxiety and fidgeting daily, became loud and disrupted the living environment, and would often wheel her chair into other residents' space. R14 had an order for PRN Ativan for high anxiety and restlessness up to three times per day. The care plan directed staff to offer R14 hand towels to fold as a mode of distraction when she becomes anxious; offer her baby doll and or cat to take care of in an attempt to distract her from her anxiety and ask family to come sit with R14 when other means of non-pharmacological measures are ineffective. The plan directed if non-pharmacological measures were ineffective, give R14's ordered PRN Ativan or her PRN pain medication for her high levels of anxiety and restlessness and provide one-on-one with R14 with reassurance when she has increased anxiety. The Physician Order, dated 04/03/24, directed staff to administer Ativan 0.5 milligrams (mg) PRN every six to eight hours for anxiety or restlessness. The stop date was marked indefinite. The Consultant Pharmacist Medication Review, dated 04/15/24, requested an Ativan PRN risk versus benefit statement from the physician. The pharmacist did not request a stop date for the PRN Ativan and the physician did not respond to the recommendation. The Physician Order, dated 06/03/24, directed staff to administer Ativan 0.5 mg PRN every eight hours for anxiety or restlessness. The stop date was marked indefinite. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Consultant Pharmacist Medication Review, dated 08/06/24, requested an Ativan PRN risk versus benefit statement from the physician but did not request a stop date. The physician's response was no change, patient doing well on current dose and no stop date was ordered. On 10/22/24 at 03:00 PM, observation revealed R14 in her wheelchair at the nurse's desk talking and lightly pulling on a phone wire, taking the paper out of the copy machine, and reaching for whatever she could reach. R14 removed her shoes and socks, and staff reapplied them. On 10/23/24 at 01:40 PM, Administrative Nurse D verified the CP should have continued to follow through until the physician provided a stop date for the PRN Ativan. The facility's Pharmacy Consultant policy, dated 04/10/24, stated the consultant pharmacist would review each resident's medication regimen at least monthly and identify irregularities. The resident-specific irregularities would be recorded and reported to the DON, medical director, and prescriber as individual recommendations and in a summary report. Recommendations would be acted upon and documented by the facility staff and or the prescriber. The prescriber accepts and acts upon suggestions or rejects and should provide an explanation for disagreeing. Recommendations concerning medication therapy would be communicated in a timely fashion and placed in the resident's medical record. The timing of these recommendations should enable a response prior to the next medication regimen review. The facility failed to ensure the CP identified and reported that R14 lacked a stop date as required for the continued use of PRN Ativan. This placed R14 at risk for complications related to psychotropic medication use beyond 14 days.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 29 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to obtain a stop date from the physician for the continued use of as-needed (PRN) Ativan (antianxiety Medication) for two residents, Resident (R) 14 and R25. This placed the residents at risk for complications related to psychotropic (alters mood or thought) medications and unnecessary medication. Findings included: - R14'sElectronic Medical Record documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and recurrent major depressive disorder (MDD- mood disorder which causes persistent feelings of sadness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R14 had short- and long-term memory problems with severely impaired decision-making. The MDS documented R14 had physical, verbal, and wandering behaviors and received antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and opioid medications (a class of controlled drugs used to treat pain). R14's Care Plan, dated 07/03/24, documented R14 was at risk for adverse behaviors related to diagnoses of dementia and anxiety. R14 has noted anxiety and fidgeting daily, became loud and disrupted the living environment, and would often wheel her chair into other residents' space. R14 had an order for PRN Ativan for high anxiety and restlessness up to three times per day. The care plan directed staff to offer R14 hand towels to fold as a mode of distraction when she becomes anxious; offer her baby doll and or cat to take care of in an attempt to distract her from her anxiety and ask family to come sit with R14 when other means of non-pharmacological measures are ineffective. The plan directed if non-pharmacological measures were ineffective, give R14's ordered PRN Ativan or her PRN pain medication for her high levels of anxiety and restlessness and provide one-on-one with R14 with reassurance when she has increased anxiety. The Physician Order, dated 04/03/24, directed staff to administer Ativan 0.5 milligrams (mg) PRN every six to eight hours for anxiety or restlessness. The stop date was marked indefinite. The Consultant Pharmacist Medication Review, dated 04/15/24, requested an Ativan PRN risk versus benefit statement from the physician. The pharmacist did not request a stop date for the PRN Ativan and the physician did not respond to the recommendation. The Physician Order, dated 06/03/24, directed staff to administer Ativan 0.5 mg PRN every eight hours for anxiety or restlessness. The stop date was marked indefinite. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Consultant Pharmacist Medication Review, dated 08/06/24, requested an Ativan PRN risk versus benefit statement from the physician but did not request a stop date. The physician's response was no change, patient doing well on current dose and no stop date was ordered. On 10/22/24 at 03:00 PM, observation revealed R14 in her wheelchair at the nurse's desk talking and lightly pulling on a phone wire, taking the paper out of the copy machine, and reaching for whatever she could reach. R14 removed her shoes and socks, and staff reapplied them. On 10/23/24 at 01:40 PM, Administrative Nurse D verified staff should have obtained a stop date for the PRN Ativan. She stated the pharmacist noted the order needed a specific duration. The facility's PRN Psychotropic Drug Use policy, dated 04/10/24, stated PRN use of a psychotropic drug was limited to 14 days unless the prescriber reviews or evaluates and documents the rationale for the extension. A duration for the PRN must be specified by the prescriber. The facility failed to obtain a 14-day stop date or a physician rationale for the continued use of PRN Ativan with a specified duration placing R14 at risk for unnecessary psychotropic medication. - R25's Electronic Medical Record documented diagnoses of heart failure, macular degeneration (progressive deterioration of the retina), and chronic pain. The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS documented R25 required staff assistance for dressing and mobility and received no psychotropic drugs. R25's Care Plan, dated 07/08/24, directed staff to introduce themselves when providing care as he had poor eyesight and explain all care and procedures before performing them. The Physician Order, dated 09/27/24, directed staff to administer Ativan 0.5 mg, every two hours as needed for restlessness or agitation, and did not include a stop date. On 10/23/24 at 03:14 PM, observation revealed R25 activated his call light as he sat in his recliner with his feet elevated and shoes on. Certified Nurse Aide (CNA) O answered and used a gait belt and walker to assist him to his feet and ambulate to the bathroom. On 10/23/24 at 01:40 PM, Administrative Nurse D verified the PRN Ativan should have a stop date. The facility's PRN Psychotropic Drug Use policy, dated 04/10/24, stated PRN use of a psychotropic drug was limited to 14 days unless the prescriber reviews or evaluates and documents the rationale for the extension. A duration for the PRN must be specified by the prescriber. The facility failed to obtain a 14-day stop date or a physician rationale for the continued use of PRN Ativan with a specified duration placing R25 at risk for unnecessary psychotropic medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37450 The facility had a census of 29 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to prepare food in a sanitary manner for two residents who requested a lettuce salad at mealtime. This placed the residents at risk for foodborne illness. Findings included: - On 10/24/24 at 11:55 AM, observation revealed Dietary Staff (DS) CC placed gloves on her hands and took a head of lettuce out of the refrigerator. DS CC then unwrapped the plastic wrap, and several layers of lettuce leaves, took the core out of the center, then went to the trash can, lifted the trash can lid, and threw away the discarded lettuce. DS CC then returned to the lettuce without changing gloves, chopped several small servings of lettuce, and placed the chopped lettuce into two small bowls. Upon inquiry, DS CC stated she had not changed her gloves following touching the trash can lid and preparing the lettuce. DS BB, who was also present, then took the two bowls, covered them with foil, and placed the bowls into the refrigerator. Upon questioning DS BB on the intent of placing the bowls of contaminated lettuce into the refrigerator, DS BB reported the bowls of lettuce were placed into the refrigerator and would be served to the residents when the residents were given their meals. Upon further inquiry regarding whether the contaminated lettuce should be served to the residents, DS BB removed the lettuce from the refrigerator and washed it in the sink, then placed the lettuce into two small bowls. The facility's Food Preparation and Handling policy, dated 04/10/24, documented that food items will be prepared using methods and techniques designed to preserve maximum nutritive value, enhance flavor, and be free of injurious organisms and substances. Gloves will be changed and hand washed between preparation of different food items and any time the gloves have been contaminated by any potentially soiled surface. The facility failed to prepare food in a sanitary manner for two residents who requested a lettuce salad at mealtime. This placed the two residents at risk for foodborne illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E637	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solomon Valley Manor	315 S Ash Street Stockton, KS 67669

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 26768 The facility had a census of 29 residents. The sample included 12 residents. Based on the interview and record review the facility lacked evidence the required committee members, including the Medical Director, attended the Quality Assurance Performance Improvement (QAPI) meetings quarterly. This placed the residents who resided in the facility at risk for decreased quality of care. Findings included: - The facility's sign-in sheets for the QAPI meetings documented that the meetings were held quarterly but lacked evidence of the medical director's attendance for the period of May through September 2024. On 10/24/24 at 01:49 PM, Administrative Staff A verified the facility's medical director did not attend a QAPI meeting in the third quarter of 2024. The facility did not provide a policy. The facility failed to ensure the medical director attended QAPI meetings at least quarterly which placed residents at risk of decreased quality of care.