STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175118	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KANSAS MASONIC HOME	402 S MARTINSON STREET WICHITA, KS 67213

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 92 residents with 21 residents in the sample. Based on observation, interview, and record review the facility failed to treat residents with dignity and respect when a Certified Nurse Aid (CNA) conversed with other staff, but not the residents she assisted with eating during dinner service. Further, the same CNA displayed an exaggerated sigh and irritated facial expression in response to a resident's request, which prompted the resident to apologize for asking for a drink. (Resident (R) 75, R55, and R43). The facility staff further failed to honor R92 and R11's preference to lay down after a meal service. Finding included: - An observation on 03/09/20 at 05:17 PM revealed Certified Nurse Aid (CNA) P assisted R75, R55, and R43 with eating. CNA P did not talk with the residents she assisted but conversed with the other CNAs in the area. CNA P made exasperated sighs when a resident made a request and one resident apologized for asking for a drink after the resident saw the expression from CNA P. During an interview on 03/10/20 at 09:06 AM, Administrative Nurse D stated she expected staff to act appropriate while caring for residents, she would not expect staff to ignore or become irritated with residents. The facility failed to provide a policy regarding Dignity as requested on 03/16/20 at 12:00 PM. The facility failed to treat residents with respect by excluding residents in conversations while providing care or services. The facility further did not treat residents with dignity by allowing staff members to show irritation at a resident's simple request. - Review of R92's signed Physician Orders, dated 03/02/20, revealed the following Diagnoses: [REDACTED]. to produce or respond to the hormone [MED] is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating normal cognitive functioning. The resident required extensive assistance of two staff for transfers, was non-ambulatory and required the help of one staff member with locomotion on and off the unit, dressing, toileting, and bathing. The resident had impaired range of motion (ROM) in the upper and lower extremity on one side. The resident was always incontinent of urine. Review of the Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 03/06/20 revealed R92 had [MEDICAL CONDITION] to embolism (blood clot). The resident had left-sided [MEDICAL CONDITION] (weakness or paralysis of the entire left or right side of the body), and the left side was her dominant side. Review of the baseline Care Plan dated 02/26/20 revealed the resident was alert and oriented. The resident required assistance of two staff for bed mobility, transfers, toilet use, grooming, and personal hygiene. Review of the nursing progress notes dated 03/09/20 revealed no records regarding the staff refusal to lay the resident down. Observation on 03/09/20 at 02:45 PM revealed the resident lay in bed on her left side with pillows for comfort and positioning. The resident was upset and presented with a flushed face. The resident reported that after she finished lunch, she asked Certified Nursing Assistant (CNA) Q to lay her down in bed. She said CNA Q told her she would have to wait for the next shift, and they could lay her down because she did not have a pressure ulcer. The resident reported she was tired and should not have to have a sore from being able to lay down. She said some staff came and laid her down after that. During an interview on 03/09/20 at 10:38 AM Certified Medication Aide (CMA) S reported when she was working on 03/09/20 after lunch, the resident asked CNA Q to lay her down as she was tired after lunch. CNA Q told the resident in the presence of another staff member that the resident could not lay down then and would have to wait until 2nd shift because she did not have a pressure ulcer so she could sit up awhile. CMA S then left and got another staff member to assist her in laying the resident down. Staff reported she told Licensed Nurse (LN) I when the incident happened and LN I helped to lay the resident down. During an interview on 3/11/19 at 2:30 PM LN I reported she knew of the incident with the resident wanted to lay down and CNA K stating she could not because she had no pressure ulcers. She and another staff CMA S put the resident to bed, and the nurse talked to CNA K about the incident. She felt she had dealt with the situation and did not report it to Administrative Nurse D. During an interview on 03/11/20 02:12 PM Administrative Nurse D reported she did not know of the concerns regarding CNA K's behaviors toward R92. Adminstrative Nurse D said expected staff to report concerns to the charge nurse and Director of Nurses (DON). Administrative Nurse D expected staff to ensure resident(s) safety and report concerns to their direct supervisor. The facility failed to provide a policy regarding resident preferences and honoring the residents choice. The facility failed to honor the residents preference to lay down after her meal concluded. - R11's clinical record included a comprehensive medical [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] identified R11 with a Brief Interview for Mental Status score of 12, which indicated moderately impaired cognition. The MDS documented R11 required extensive assistance of one to two staff for all activities of daily living (ADLs), total dependence on staff for transfers, and had a range of motion impairment on one upper and one lower extremity. The Care Area Assessment (CAA) dated 06/29/19 for ADL Function documented R11 required the use of an electronic lift for transfers. An observation on 03/11/20 at 12:16 PM revealed R11 sat up in her wheelchair in the dining room, and received assistance with meal from Certified Medication Aid (CMA) R. An interview on 03/11/20 at 12:39 PM with Certified Nurse Assistant (CNA) LL stated she witnessed R11 request to be put to bed after supper and Licensed Nurse (LN) KK told R11 she had to wait for everyone else to finish supper and they would get to her when they get to her. CNA LL stated R11 always went to bed as soon as she finished eating supper, so CNA LL received help from another unidentified staff member to put R11 to bed after supper. An interview on 03/11/20 at approximately 02:00 PM with Administrative Staff B revealed no allegations about LN KK were reported to him. An interview on 03/11/20 at 02:12 PM with Administrative Nurse D stated no allegations about LN KK were reported to her. Administrative Nurse D stated she expected staff to always ensure resident safety and to report concerns to the direct supervisor and any concerns with the charge nurse were reported immediately by calling Administrative Nurse D or Administrative Staff B. The facility failed to provide a policy regarding resident preferences and honoring resident choices. The facility failed to honor R11's preference and right to lay down after a meal service.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 92 residents, with 21 residents selected for sample. Based on interview and record review, the facility failed to promptly notify Resident (R) 66's physician when she developed a significant change in her physical condition. Several hours later staff noted additional changes in R66's condition and contacted the physician. R66 transferred to the hospital via ambulance. R66 was admitted to the hospital with [REDACTED]. Findings included: - Resident (R) 66 admitted to the facility on [DATE] with multiple medical [DIAGNOSES REDACTED]. The 02/14/20 Admission

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

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.

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Minimum Data Set identified R66 with moderate cognitive impairment (Brief Interview for Mental Status score of 11), the need for extensive assistance of one to two staff for assistance with activities of daily living (ADLs), and no terminal [DIAGNOSES REDACTED]. The 02/20/20 Care Plan noted R66's plans to return to the community upon discharge from the facility. physician progress notes [REDACTED]. The entry included a [DIAGNOSES REDACTED]. According to the note, R66 received [MEDICATION NAME], an antibiotic used to treat bacterial infections, prior to 02/10/20, and the physician ordered continuation of that medication. The note also included an order for [REDACTED]. that results from prolonged pressure). The note included orders for wound treatment. Interdisciplinary Progress Notes included the following: 1) 02/28/20 (time unknown): Described R66's lethargy (lack of energy) and described her as unable to rouse and wound not follow commands. Staff notified R66's son and physician of this change in condition. 2) 02/29/20 on the 6-2 shift described R66's improvement and noted the resident ate breakfast and lunch in the dining room. 3) 03/01/20 on the 6-2 shift (no exact time given): Described R66 as lethargic and unable to rouse, very warm to the touch and breathing rapid. The note included an explanation that family members reported R66's condition was normal after she received narcotic medication. The note included vital sign measurements which included a blood pressure reading of 105/60 (normal blood pressure for older adults is 120/80), pulse rate of 98 (normal pulse rate for older adults is 60-100), respiratory rate of 36 (normal respiratory rate in older adults is 15-25), temperature of 99.3 degrees Fahrenheit (F)(normal temperature for an older adult is 96.5 - 97.5 F) and an oxygen saturation level of 94%. According to note, staff planned to continue to monitor R66's condition. The note lacked mention of physician notification of the change in R66's condition. The documentation also lacked evidence of additional assessments of vital signs/oxygen saturation levels in the hours after staff first noted the previously noted values. 4) 03/01/20 on the 2-10 shift (no exact time documented): Described R66 as unresponsive on this shift. According to the note, staff contacted the on call physician who ordered transfer to a local emergency room for evaluation and treatment. The note lacked the time of physician notification or the time of the order. The entry noted the time of transfer to the hospital as 10:15 PM. The progress note lacked evidence staff assessed R66's vital signs in the eight-hour time period between when the shift started at 02:00 PM and 10:00 PM. The 03/01/20 Emergency Department Clinical Summary from the hospital which received R66 in transfer listed an admission rectal temperature of 38.8 degrees Celsius (101.8 degrees F), respiratory rate of 22, and a diastolic blood pressure (bottom number of the blood pressure which measures pressure within the vessels between contractions of the heart) of 43 which emergency staff described as low. The 03/01/20 History and Physical from the admitting hospital listed the admission [DIAGNOSES REDACTED]. Administrative Nurse D sent written communication/email on 03/18/20 at 04:26 PM in which she confirmed staff failed to complete nursing assessments of R66 in the hours after they first noticed a significant change in vital signs and level of consciousness. According to Administrative Nurse D, when staff noticed changes late in the following shift, they immediately contacted the physician and subsequently sent the resident to the hospital. Administrative Nurse D also reported she expected staff to assess the condition of wounds (such as the abscess on R66's neck) and document those findings in the clinical record. Administrative Nurse D reported staff failed to put the orders for wound treatment on the TAR, and therefore staff failed to complete the wound dressing changes for 18 days as ordered by the physician. Attempts to contact R66's physician at the phone number provided by the facility were unsuccessful on 03/18/20 at 11:00 AM, 02:45 PM, and 05:30 PM. Administrative Nurse D reported the facility lacked policies related to nursing assessment of significant changes in medical condition and assessment/documentation of non-pressure wounds. The facility failed to ensure staff provided R66 with routine assessment and monitoring of a non-pressure skin condition/abscess on the neck, and timely and thorough assessments of changes in the level of consciousness and vital signs. When R66 experienced a change in the level of consciousness and change in vital signs, staff failed to notify the physician of the changes and failed to complete thorough, timely nursing assessments in the hours following the original observation of changes. Over the next at least eight hours, R66 experienced additional deterioration in her condition which necessitated transfer to the hospital via ambulance, and subsequent admission to the hospital with a primary [DIAGNOSES REDACTED].
F 0607 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** The facility census totaled 92 residents. Based on interview and record review the facility failed to conduct thorough screening of employees when the facility failed to obtain information from previous and or current employers for five of five hired employee's as reviewed. Findings included: - Review of employee files on 03/12/20 at 11:57 AM revealed lack of reference checks prior to employment at the facility for five of five records reviewed, as follows: 1. Review of Certified Nurse Aide (CNA) M preemployment screening information, with a date of hire of 12/23/19, revealed the file lacked reference checks attempted and/or completed by the facility for previous/and or current employers prior to the date of hire of CNA M. 2. Review of Certified Nurse Aide (CNA) N preemployment screening information, with a date of hire of 01/13/20 revealed the file lacked reference checks attempted and/or completed by the facility for previous/and or current employers prior to the date of hire of CNA N. 3. Review of Licensed Nurse (LN) G preemployment screening information, with a date of hire of 01/13/20 revealed the file lacked reference checks attempted and/or completed by the facility for previous/and or current employers prior to the date of hire of LN G. 4. Review of Certified Nurse Aide (CNA) O preemployment screening information, with a date of hire of 02/17/20 revealed the file lacked reference checks attempted and/or completed by the facility for previous/and or current employers prior to the date of hire of CNA O. 5. Review of Housekeeping Aide (HA) U preemployment screening information, with a date of hire of 03/09/20 revealed the file lacked reference checks attempted and/or completed by the facility for previous/and or current employers prior to the date of hire of HA U. Interview with Administrative Staff A on 03/12/20 at 02:19 PM revealed she did not completed the reference checks and said a lot of the employees were hired on the same day as the interview. Interview with Administrative Nurse D on 03/16/20 at 09:28 PM revealed she expected Administrative Staff A to completed reference checks to ensure the applicant were eligible to hire. Review of the Abuse, Neglect and Exploitation Prevention policy revised 09/17 revealed personal and professional references listed on job applications were checked on selected individuals and those reference verifications may be conducted by telephone or letter. The policy further revealed a record of the reference check would be maintained in the employee packet. The facility failed to obtain previous/and or current reference check on five of five employee records reviewed.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 92 residents, with 21 included in the sample. Based on observation, interview, and record review, the facility failed to report injuries of unknown origin on resident (R) 66. Findings included: - R66's clinical record included a comprehensive medical [DIAGNOSES REDACTED]. The 02/14/20 Admission Minimum Data Set (MDS) identified R66 with moderate cognitive impairment (Brief Interview for Mental Status score of 11), and the need for extensive assistance of one to two staff for all activities of daily living (ADLs). Interdisciplinary Progress Notes dated 02/07/20 at 06:00 PM included, Resident's son reported that resident has 2 bruises on her left arm that wasn't there before she got here. He thinks maybe someone grabbed her arm and she bruises easily because of the blood thinners is what he said. I filled out an incident report. In response to a request for an investigation of R66's bruises/injuries of unknown origin, Administrative Nurse D provided a 02/07/20 Incident Report which described two left arm red bruises which measured 5.4 centimeters (cm) by 6.6 cm and 4.5 cm by 3.8 cm. The only narrative on the document described R66's son's report of the bruises which were not present at the time of admission on 02/03/20, and which he thought might be contributed to use of blood thinners (medications used to decrease coagulation of blood). Administrative Nurse D sent written communication/email on 03/16/20 at 02:46 PM related to R66's bruises of unknown origin. According to Nurse D, It wasn't a suspicious bruise or injury. The email went on to explain referral to Occupational Therapy for wheelchair positioning following identification of the bruises. According to Administrative Nurse D, The bruising was not of a handprint. Administrative Nurse D was unable to provide evidence the facility reported the injuries of unknown origin and the son's allegation of abuse to the State Survey and Certification Agency and then thoroughly investigated the injuries and documented the investigation. The facility's 09/2017 Abuse, Neglect and Exploitation Prevention Policy lacked guidance related to injuries of unknown origin and/or reporting of all allegations of abuse, neglect and exploitation. The facility failed to report and thoroughly investigate an allegation of abuse/injuries of unknown origin (bruises to R66's left arm) after a family member reported the bruises and stated the bruises looked like someone grabbed her by the arms.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2)
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 92 residents and a sample of 21. Based on observation, interview, and record review the facility failed to notify the Ombudsman of Resident (R) 28's facility initiated hospitalized transfer and per interview with facility staff the facility failed to notify the Ombudsman regarding hospitalization s for any resident. Findings included: - Review of R28's unsigned electronic medical [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for discharge date d 12/17/19, documented an unplanned discharge to acute hospital with return anticipated. Review of the MDS for entry dated 12/18/19 documented entry record from acute hospital stay. Review of R28's care plan revised on 12/17/19 documented a fall with injury and noted a hospitalization transfer via Emergency Medical Services (EMS). Review of the physician's orders [REDACTED]. Upon request, the facility did not provide copies of notices to the Ombudsman of R28's facility-initiated hospitalization transfers. An observation on 03/12/20 at 07:41 AM revealed R28 sat up in wheelchair at the dining room table and talked with other tablemates An interview on 03/11/20 at 4:00 PM with Administrative Nurse D stated the facility did not notify the Ombudsman of R28's hospitalization transfer and did not notify the Ombudsman regarding any resident hospitalization transfer. An interview on 03/17/20 at 11:17 AM with Administrative Staff B stated the facility did not notify the Ombudsman of R28's hospitalization transfer and did not notify the Ombudsman about any residents hospitalization s. Although requested, the facility did not provide a policy for regarding Ombudsman notification of transfers/discharges to the hospital as requested on 03/16/20. The facility failed to notify the Ombudsman of R28's facility-initiated hospitalization transfer on 12/17/19 and failed to notify the Ombudsman of hospitalization s for any resident.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** The facility census totaled 92 residents (R) with 21 residents in the sample. Based on interview and record review the facility failed to accurately reflect the number of falls experienced by R75 on the 02/21/20 Minimum Data Set (MDS) assessment, when the MDS noted only two falls instead of the four actual falls the resident experienced during the review period. Findings included: - Review of the R75's 02/21/20 Quarterly MDS revealed a BIMS of four, indicating severely impaired cognition. The resident required limited one-person assistance for transfers, had an unsteady gait and used a walker. R75 had one non-injury fall and one minor injury fall noted during the review period. Review of November 26th 2019 to March 21st 2020 fall investigations revealed the resident experienced falls on the following dates which were not noted on the 02/21/20 Quarterly MDS: 1. 12/24/19 at 7:00 PM 2. 12/26/19 at 11:15 AM 3. 01/12/20 at 05:50 AM 4. 01/29/20 at 09:00 PM Interview with MDS Coordinator C on 03/16/20 at 10:16 AM revealed she looked through the resident's chart and records and stated she only found two falls. The facility failed to provide a policy regarding MDS accuracy as requested on 03/16/20 at 10:00AM. The facility failed to complete the MDS accurately to reflect the four falls experienced by R75 during the review period.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 92 residents with 21 residents included in the sample and one resident sampled for oxygen use. Based on observation, interview, and record review the facility failed to develop a comprehensive person-centered care plan for Resident (R)78 to include respiratory care and treatment regarding the use of supplemental oxygen. Findings included: - Review of the Annual Minimum Data Set (MDS) for R78, dated 02/20/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R78 with shortness of breath, [MEDICAL CONDITION], and supplemental oxygen. Review of the Care Plan revised 02/20/20 lacked instructions and/or interventions regarding the use of supplemental oxygen for R78. An observation on 03/09/20 at 05:22 PM revealed R78 sat in her wheelchair visiting with family in her room, with oxygen tubing on. Observation revealed the oxygen tubing contained a date of 03/01/20 and the humidifier on the concentrator was dated 02/01/20. An interview on 03/11/20 at 10:16 AM with Certified Medication Aid (CMA) R stated oxygen tubing and humidifiers were changed every week on Sunday nights and documented on the Treatment Administration Record (TAR). An interview on 03/11/20 at 10:19 AM with Licensed Nurse LN L stated staff changed the oxygen tubing and humidifiers weekly and as needed. LN L confirmed oxygen tubing and humidifier were outdated. An interview on 03/16/20 at 10:11 AM with LN K stated she expected supplemental oxygen use to be on the care plan and reported that Administrative Nurse D or other Registered Nurses (RN's) updated the care plan. An interview on 03/16/20 at 09:16 AM with Administrative Nurse D stated she expected oxygen use to be on the care plan and reported she and other nurses updated the care plan. The facility's policy titled, Care Planning and Resident Assessment, dated 11/2016, documented the care plan described considerations and interventions needed for adequate care. The policy lacked information specific to respiratory care and/or the use of supplemental oxygen. The facility failed to develop a comprehensive person-centered care plan for R78 when the care plan lacked interventions to include respiratory care and treatment regarding the use of supplemental oxygen for R78.
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** The facility had a census of 92 residents, with 21 residents selected for sample. Based on observation, interview and record review, the facility failed to review/revise care plans for three of 21 residents to include measurable goals and resident specific interventions related to development of a facility acquired pressure ulcer (Resident (R) 66), falls (R75), and activities of daily living (R46). Findings included: - Resident (R) 66 admitted to the facility on [DATE]. The 02/14/20 Admission Minimum Data Set identified R66 with moderate cognitive impairment (Brief Interview for Mental Status score of 11), the need for extensive assistance of one staff for bed mobility and transfers, and an inability to ambulate. R66 experienced frequent bladder incontinence and occasional bowel incontinence. The assessment identified R66 with no pressure ulcers or other skin problems. The 02/20/20 Care Plan identified R66 as at risk for pressure ulcers. The care plan described a non-pressure skin issue (abscess - cavity containing pus and surrounded by inflamed tissue) but lacked information related to a current pressure ulcer. A 02/18/20 physician progress notes [REDACTED]. Diagnosis: [REDACTED]. Air mattress, turn every 2 hours, cleans this site with normal saline and apply foam dressing. Change every 72 hours and as needed. Staff to notify nurse practitioner/PA (physician's assistant)/ or doctor of any further breakdown should it occur. Interdisciplinary Progress Notes included, 1) 02/17/20 at 08:00 PM: Redness noted on coccyx. Foam dressing applied to the area to prevent sores. 2) 02/18/20 (no time recorded): New order for air mattress for coccyx breakdown. The entry also repeated the physician's orders [REDACTED]. R66's care plan lacked evidence of review/revision after she developed a facility acquired pressure ulcer/deep tissue injury to the coccyx, to include measurable goals and resident specific interventions for wound management. Administrative Nurse D provided written communication via email on 03/18/20 at 04:26 PM in which she confirmed staff failed to review/revise R66's care plan following development of skin breakdown to the coccyx The facility's 11/2016 Care Planning and Resident Assessment policy directed the clinical coordinator to make updates to the care plan at least quarterly and with every change of condition. The facility failed to review/revise the care plans for R66 to include measurable goals and resident specific interventions related to a facility acquired pressure ulcer. - Review of R75's pertinent [DIAGNOSES REDACTED]. Review of the 02/21/20 Quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) of four, indicating severely impaired cognition. She had two falls coded as occurring during the three-month review period. Review of the Falls Care Area Assessment (CAA) dated 11/26/19 revealed R75 was at risk for falls, she ambulated with a walker and required cues and reminders to use the walker. She had an unsteady stance and turning gait, and visual hallucinations which increased her risk for falls. Review of R75's Cognitive Loss Care Plan, last revised 12/06/19, revealed the resident had cognitive loss/impairment and directed the staff to encourage the resident

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) to use her walker and ensure she had on proper footwear. Review of the Activities of Daily Living Care Plan (ADL), last revised on 12/06/19, directed the staff to: 1. Remind the resident to use her walker. 2. Provide supervision/limited assist for bed mobility, transfers, walking, toileting as needed for safety. 3. A walker had recently been added for my safety. 4. Analyze falls to determine pattern/trend. 5. Assist in minimizing clutter in the immediate environment. 6. Assure eyeglasses are clean and in good repair. 7. Fall risk assessment on admission, quarterly, and as needed. 8. Keep call light in reach at all times. Remind her to use the call light as needed 9. Keep personal and frequently used items within reach. 10. Leave night light on in room. 11. Utilize Physical and Occupational Therapy as needed. 12. Orient her when there has been new furniture placement or other changes in environment. 13. Provide proper, well-maintained footwear. The care plan above revealed no updates/revisions since 12/06/19. Review of November 2019 to March 2020 fall investigations revealed R78 experienced falls on the following seven dates (with no care plan revisions noted): 1. 11/19/19 2. 12/24/19 3. 12/26/19 4. 01/12/20 5. 01/29/20 6. 02/22/20 7. 02/27/20 Observation of R75 on 03/12/20 at 09:54 AM revealed the resident ambulating independently without her walker in the hall from her room to the dining room. Dietary Aide CC was in the kitchen and helped R75 set down in a chair in the dining area. She then tried to locate staff and eventually located and activity assistant to assist the resident. Interview with Administrative Nurse D on 03/12/20 12:54 PM revealed she expected interventions to be updated on the care plan, and a new intervention placed according to why the resident fell . Review of 03/2017 Falls and Fall Prevention policy revealed the facility would review the plan of care to ensure the interventions are documented, resident specific, and appropriate follow-up is occurring. Review of 11/2016 Care Planning and Resident Assessment policy revealed the care plan would describe special considerations and interventions needed for adequate care. The clinical coordinator would review the care plan and make updates at least quarterly and with every change of condition. Other staff associated with the care of the resident could also make changes to the care plan as needed. The facility failed to update/revise R75'2 care plan with appropriate interventions after each of seven falls to reduce R75's risk for further falls.
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** The facility census totaled 92 residents (R) with 21 residents in the sample. Based on observation, interview, and record review the facility failed to provide the Activities of Daily Living (ADL) for R46 to include grooming and oral care. Finding included: - Review of R46's pertinent [DIAGNOSES REDACTED]. fibrillation (an irregular and often rapid heart rate), and generalized muscle weakness. Review of the 08/05/19 Admission Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident did not reject care during the review period. R46 required extensive two-person assistance for transfers and required limited one-person assistance with personal hygiene. She did not have a steady gait and used a wheelchair for mobility. Review of the 01/22/20 Quarterly MDS revealed a BIMS of 15, indicating intact cognition. The resident did not reject care during the review period. The resident required extensive two-person assistance for transfers and limited one-person assistance for personal hygiene. She did not have a steady gait and used a wheelchair. Review of the 08/05/19 Activities of Daily Living (ADL) Care Area Assessment (CAA) revealed R46 as a pleasant woman, alert and oriented with a BIMS of 15. Her speech was clear and she could make her needs known. The resident had her own teeth and noted in great repair. She told staff she has had two [MEDICAL CONDITION], each affecting a different body part. She could not ambulate at the time of the interview. Review of revised 08/07/19 ADL Care Plan revealed R46 needed assistance in completing her daily cares. She preferred to awaken on her own in the mornings, usually awake by 08:30 AM and did not like to feel rushed. Her level of assistance with transfers and hygiene could vary; the staff were to provide the level of assistance necessary for safety. She needed the assistance of two staff for transfers, with use of a gait belt. Review of 08/06/19-11/27/19 Occupational Therapy (OT) Discharge Summary and 07/25/19-11/27/19 Physical Therapy (PT) Discharge Summary revealed no indicator of how many times a week to work with resident for personal hygiene. Review of 03-10/20- 03/16/20 daily ADL report personal hygiene CNA charting revealed: 03/10/20 documentation indicated CNA staff provided personal hygiene once. 03/11/20 documentation lacked evidence CNA staff provided personal hygiene. 03/12/20 documentation indicated CNA staff provided personal hygiene once. 03/13/20 documentation indicated CNA staff provided personal hygiene once. 03/14/20 documentation lacked evidence CNA staff provided personal hygiene. 03/15/20 documentation indicated CNA staff provided personal hygiene once. 03/16/20 documentation lacked evidence CNA staff provided personal hygiene. Observation of R46 on 03/11/20 at 08:15 AM revealed the resident in bed with the call light in reach. The resident's hair appeared disheveled; teeth were noted to have thick plaque with no indicators of ADLs completed. Observation of R46 on 03/11/20 at 12:34 PM revealed the resident in bed and her call light within reach. The resident's hair continued to look disheveled and not groomed, and when asked if the CNA's had come in to help brush her teeth and assist with grooming, R46 stated no, not yet today. Observation of R46 on 03/12/20 at 08:45 AM revealed resident in bed with call light in reach. Hair was disheveled, teeth noted with plaque and appeared unbrushed. Interview with R46 on 03/09/20 at 03:02 PM revealed at 02:00 PM every day, she was to be transferred from her recliner to her bed to rest, but no staff assisted her today Interview with CNA T on 03/11/20 at 09:57AM revealed R46 woke up at about 10:00 AM, and staff were to assist the resident to brush her hair and teeth, and then set her in her recliner. R46 wanted laid down right before 02:00 PM every day. CNA T stated most of the time the staff could lay her down right before 02:00 PM, but sometimes staff got really busy and could not. Interview with Physical Therapy Assistant X on 03/11/20 at 12:45 PM revealed the nurses and Certified Nurse's Aides (CN's) should have completed the restorative recommendations with the resident for grooming and personal hygiene, from five to seven times a week. CNAs were instructed to provide encouragement to R46 for grooming and personal hygiene. Staff were to allow the resident the opportunity to perform grooming tasks at her sink. The CNAs charted those tasks in the kiosk. Interview with Licensed Nurse E on 03/12/20 at 10:06 AM revealed the CNAs should assist the resident with brushing her teeth and grooming when she got up in the morning. This house was down a staff member at this time, so the Certified Medication Aide (CMA) and CNA are working towards providing resident cares. Interview with LN K on 03/16/20 at 09:41 AM revealed R46 would let staff brush her hair, and the CNA's let her brush her teeth or do it for her if she was feeling weak. The CNAs assisted with grooming and personal hygiene and documented it in the kiosk. Interview with Administrative Nurse D on 03/11/20 at 01:10 PM revealed the CNAs charted for grooming and personal hygiene and expected recommendations to be documented. Interview with Administrative Nurse D on 03/17/20 at 11:00 AM revealed she expected the CNAs to complete ADLs such as grooming, brushing teeth, and assisting the resident to transfer to her recliner. The facility failed to provide a policy regarding ADLs as requested on 03/16/20 at 10:00AM. The facility failed to provide the Activities of Daily Living (ADL) for R46 to include grooming and oral care.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 92 residents, with 21 residents selected for the sample. Based on observation, interview, and record review, the facility failed to ensure staff provided two of 21 residents with the quality of care (assessment and monitoring of a non-pressure skin condition/abscess, assessment of changes in medical condition for resident (R)66; assessment of daily weights for R44). Resident 66 experienced a change in the level of consciousness and change in vital signs. Staff failed to notify the physician of the changes and failed to complete thorough, timely nursing assessments in the hours following the original observation of changes. Over the next at least eight hours, R66 experienced additional deterioration in her condition which necessitated transfer to the hospital via ambulance, and subsequent admission to the hospital with a primary [DIAGNOSES REDACTED]. The facility further failed to perform daily weight monitoring as ordered by the physician for R44 who recieved [MEDICAL TREATMENT] and was at risk for fluid volume excess. Findings included: - R66 admitted to the facility on [DATE] with multiple medical [DIAGNOSES REDACTED]. The 02/14/20 Admission Minimum Data Set identified R66 with moderate cognitive impairment (Brief Interview for Mental Status score of 11), the need for extensive assistance of one to two staff for assistance with activities of daily living (ADL), and no terminal [DIAGNOSES REDACTED]. The 02/20/20 Care Plan noted R66's plans to return to the community upon discharge from the facility. physician progress notes [REDACTED]. The entry included a [DIAGNOSES REDACTED]. According to the note, R66 received [MEDICATION NAME], an

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) antibiotic used to treat bacterial infections before 02/10/20, and the physician ordered the continuation of that medication. The record also included an order for [REDACTED]. The clinical record also lacked evidence staff followed the physician's 02/10/20 order for wound/abscess treatment in the 18 days from 02/10/20 - 02/28/20. According to the Treatment Administration Record (TAR), the staff completed the first dressing change to the wound on 02/28/20. Interdisciplinary Progress Notes included the following: 1) 02/28/20 (time unknown): Described R66's lethargy (lack of energy) and described her as unable to rouse and wound not follow commands. Staff notified R66's son and physician of this change in condition. 2) 02/29/20 on the 6-2 shift described R66's improvement and noted the resident ate breakfast and lunch in the dining room. 3) 03/01/20 on the 6-2 shift (no exact time given): Described R66 as lethargic and unable to rouse, very warm to the touch and breathing rapid. The note included an explanation that family members reported R66's condition was normal after she received narcotic medication. The note included vital sign measurements which included a blood pressure reading of 105/60 (normal blood pressure for older adults is 120/80), pulse rate of 98 (normal pulse rate for older adults is 60-100), respiratory rate of 36 (normal respiratory rate in older adults is 15-25), temperature of 99.3 degrees Fahrenheit (F)(normal temperature for an older adult is 96.5 - 97.5 F) and an oxygen saturation level of 94%. According to the note, the staff planned to continue to monitor R66's condition. The record lacked mention of physician notification of the change in R66's condition. The documentation also lacked evidence of additional assessments of vital signs/oxygen saturation levels in the hours after staff first documented the previously noted values. 4) 03/01/20 on the 2-10 shift (no exact time documented): Described R66 as unresponsive on this shift. According to the note, staff contacted the on-call physician who ordered a transfer to a local emergency room for evaluation and treatment. The note lacked the time of physician notification or the time the physician ordered a transfer to the hospital. The entry noted the time of transfer to the hospital at 10:15 PM. The progress note lacked evidence staff assessed R66's vital signs in the eight hours between when the shift started at 02:00 PM and 10:15 PM when the resident transferred to the hospital. The 03/01/20 Emergency Department Clinical Summary from the hospital, listed an admission rectal temperature of 38.8 degrees Celsius (101.8 degrees F), respiratory rate of 22, and a diastolic blood pressure (the bottom number of the blood pressure which measures the pressure within the vessels between contractions of the heart) of 43 which emergency staff described as low. The 03/01/20 History and Physical from the admitting hospital listed the admission [DIAGNOSES REDACTED]. Administrative Nurse D sent written communication/email on 03/18/20 at 04:26 PM in which she confirmed staff failed to complete nursing assessments of R66 in the hours after they first noticed a significant change in vital signs and level of consciousness. According to Administrative Nurse D, when staff noticed changes late in the following shift, they immediately contacted the physician and subsequently sent the resident to the hospital. Administrative Nurse D also reported she expected staff to assess the condition of wounds (such as the abscess on R66's neck) and document those findings in the clinical record. Administrative Nurse D reported staff failed to put the orders for wound treatment on the TAR, and therefore staff failed to complete the wound dressing changes for 18 days as ordered by the physician. Attempts to contact R66's physician at the phone number provided by the facility were unsuccessful on 03/18/20 at 11:00 AM, 02:45 PM, and 05:30 PM. Administrative Nurse D reported the facility lacked policies related to nursing assessment of significant changes in medical condition and assessment/documentation of non-pressure wounds. The facility failed to ensure staff provided R66 with routine assessment and monitoring of a non-pressure skin condition/abscess on the neck, and timely and thorough assessments of changes in the level of consciousness and vital signs. When R66 experienced a change in the level of consciousness and change in vital signs, staff failed to notify the physician of the changes and failed to complete thorough, timely nursing assessments in the hours following the original observation of changes. Over the next at least eight hours, R66 experienced additional deterioration in her condition which necessitated transfer to the hospital via ambulance, and subsequent admission to the hospital with a primary [DIAGNOSES REDACTED]. - Review of resident R44's pertinent [DIAGNOSES REDACTED]. Review of the 10/30/19 Annual Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R44 weighed 209 pounds (lbs) and required [MEDICAL TREATMENT] (a blood purifying treatment given when kidney function is not optimum) treatment at the time of the assessment. Review of the 01/04/20 Quarterly MDS revealed a BIMS of 15, indicating intact cognition. R44 had a recorded weight of 221 lbs. and required [MEDICAL TREATMENT] at the time of the assessment. Review of the Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 10/30/19 revealed R44 had no significant change in her ability to perform her ADLs daily over the past year with a continued need for [MEDICAL TREATMENT], related to end stage kidney disease. She was independent for personal hygiene and eating and received outpatient [MEDICAL TREATMENT] three days a week. Review of the Fluid Maintenance CAA dated 10/30/2020 revealed R 44 was at risk for dehydration. She had end stage [MEDICAL CONDITION] which required [MEDICAL TREATMENT] three days a week and was on a fluid restriction of 1000 milliliters (ml) per day, Review of R44's Care Plan dated 10/31/19 revealed she was at risk for fluid volume excess and directed the staff to assess and monitor for fluid excess (weight gain, increased blood pressure, full/bounding pulse, jugular vein distention, SOB, moist cough, rales, rhonchi, wheezing, [MEDICAL CONDITION], worsening of [MEDICAL CONDITION], increased urinary output, nausea/vomiting, liquid stools). And that R44 was on a fluid restriction of 1000 milliliters of fluids per 24-hour period. The amount of fluids she could have varied frequently, depending on how her [MEDICAL TREATMENT] went. She was alert and oriented and able to follow through with fluid restriction. Review of R44 Weight Detail Report revealed the facility failed to weigh the resident daily per the physician's orders [REDACTED]. Review of the physician's orders [REDACTED]. Observation of R44 on 03/11/20 at 09:28 AM revealed the resident dressed in her wheelchair and ready for [MEDICAL TREATMENT]. The resident ate breakfast, staff obtained her vital signs, and she waited at the nurses' station to go to [MEDICAL TREATMENT]. Interview with R44 03/11/20 at 09:21 AM revealed the staff occasionally obtained her vital signs but revealed the facility failed to monitor her weight. The [MEDICAL TREATMENT] center watched her weight before and after the completion of [MEDICAL TREATMENT]. Interview with Licensed Nurse (LN) F on 03/11/20 at 04:39 PM revealed the [MEDICAL TREATMENT] center obtained her vital signs after [MEDICAL TREATMENT], her weights before and after [MEDICAL TREATMENT], and the facility documented her fluids every shift. Interview with Administrative Nurse D on 03/12/20 at 01:58 PM revealed she expected the the facility dietician to do monthly reviews of the resident's chart for weight documentation. Interview on 03/17/20 at 11:00 AM with Administrative Nurse D revealed R44's weights were completed daily per the physician's orders [REDACTED]. The facility failed to provide a policy regarding weights and monitoring as requested on 03/16/20 at 10:00 AM. The facility failed to perform daily weight monitoring as ordered by the physician for R44 who was on [MEDICAL TREATMENT] and at risk for fluid volume excess.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 92 residents, with 21 residents selected for sample. Three sampled residents had 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/friction). Based on observation, interview and record review, the facility failed to ensure three of three residents with pressure ulcers received the necessary care to prevent pressure ulcers (weekly skin assessments in an attempt to identify early skin changes) and the necessary treatment and services (routine measurement and assessment of existing pressure ulcers, implementation of pressure reduction interventions, timely implementation of physician ordered wound treatment for [REDACTED]. (Residents (R) 66, 86, and R91) Findings included: - R66 admitted to the facility on [DATE]. The comprehensive medical [DIAGNOSES REDACTED]. The 02/14/20 Admission Minimum Data Set identified R66 with moderate cognitive impairment (Brief Interview for Mental Status score of 11), the need for extensive assistance of one staff for bed mobility and transfers, and an inability to ambulate. R66 experienced frequent bladder incontinence and occasional bowel incontinence. The assessment identified R66 with no pressure ulcers or other skin problems. Care Area Assessments (CAAs) completed on 02/14/20 identified R66 as at risk for skin injury due to incontinence of bowel and bladder. The 02/20/20 Care Plan included interventions related to R66's use of a mechanical lift for transfers and need for assistance of one staff for bed mobility. The care plan identified R66 as at risk for pressure ulcers. The care plan described a non-pressure skin issue (abscess - cavity containing pus and surrounded by inflamed tissue) but lacked information related to a current pressure ulcer. The care plan directed licensed nursing staff to complete a weekly skin assessment. The 02/03/20 Braden Skin Assessment (an assessment to determine the risk of skin breakdown) identified R66 as mild risk for skin breakdown. Skin Monitoring Comprehensive Skin Review and Weekly Skin Check Sheet documentation lacked evidence of licensed nurse completion of weekly skin assessments as directed by the care plan. Skin documentation included the following: 1) 02/03/20 (date of admission) and 02/04/20: Skin Monitoring Comprehensive Skin Review sheets identified no

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) current skin issues. A sheet completed on 02/26/20 referred only to bruised knees related to fall and lacked evidence of assessment of other areas. 2) Weekly Skin Check Sheet: The clinical record lacked evidence of completion of weekly skin assessments as directed by the care plan since admission on 02/03/20. A 02/18/20 physician progress notes [REDACTED]. Diagnosis: [REDACTED]. Air mattress, turn every 2 hours, cleans this site with normal saline and apply foam dressing. Change every 72 hours and as needed. Staff to notify nurse practitioner/PA (physician's assistant)/ or doctor of any further breakdown should it occur. Treatment Administration Records (TARs) for February 2020 lacked evidence staff completed dressing changes to the coccyx as ordered by the physician in the ten-day time period from 02/18/20 - 02/28/20. According to the TAR, staff completed the first dressing change on 02/28/20. Interdisciplinary Progress Notes included, 1) 02/17/20 at 08:00 PM: Redness noted on coccyx. Foam dressing applied to the area to prevent sores. 2) 02/18/20 (no time recorded): New order for air mattress for coccyx breakdown. The entry also repeated the physician's orders [REDACTED]. 3) 03/01/20 on the 2-10 shift: Described a change in R66's medical condition and subsequent transfer to the hospital. As of 03/13/20, R66 remained in the hospital. Although requested, Administrative Nurse D did not provide additional documentation related to evidence of weekly skin assessments prior to development of the deep tissue injury to the coccyx, assessment/measurement/staging of R66's coccyx wound after identification on 02/17/20, or evidence staff implemented wound treatments and dressing changes within the 10 day time period after the physician wrote the orders. During an interview on 03/13/20 at 11:05 AM, Licensed Nurse L reported nurses assigned to each household have responsibility to complete weekly skin assessments. Licensed Nurse L looked through R66's chart and was unable to find evidence of such assessments. Nurse L denied knowledge R66 developed an area of skin breakdown to the coccyx after admission to the facility. Administrative Nurse D provided written communication via email on 03/18/20 at 04:26 PM in which she confirmed staff failed to complete weekly skin assessments for R66 prior to development of skin breakdown on the coccyx. Nurse D also reported she expected licensed nursing staff to assess wounds and then document their findings in the clinical record. The facility's 03/2017 Pressure Ulcer Prevention, Bruises, Skin Tear policy directed non-licensed staff to check skin during baths and notify the licensed nurse of concerns. The policy lacked guidance related to documentation and care of pressure ulcers. The facility failed to ensure R66 received the necessary care to prevent pressure ulcers (weekly skin assessments in an attempt to identify early skin changes) and the necessary treatment and services (routine measurement and assessment of a facility acquired pressure ulcer, timely implementation of physician ordered wound treatment for [REDACTED]. - Review of R86's Physician order [REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) revealed a score of 15, indicating intact cognition. The MDS indicated R86 was at risk for developing pressure ulcers. R86 admitted with was unstageable (being unable to see the base of the pressure ulcer) pressure ulcer with slough (dead tissue) noted. The facility had pressure reducing devices for bed and chair in use and provided surgical wound care and antibiotic medications. Review of the Care Area Assessment (CAA) dated 02/26/20 for pressure ulcer revealed R86 currently has an unstageable pressure ulcer to her sacral region from admission with negative pressure wound therapy (NPWT-mechanical device to aid with wound healing) and on IV (intravenous) antibiotic for infection to wound. Review of R86 medical record, from admission date of [DATE] to 03/09/20, lacked documentation regarding the width, length, and depth of the pressure ulcer located on R86's sacrum area during wound dressing changes for the following dates, 02/19/20, 02/21/20, 0[DATE], 02/26/20, 02/28/20, 03/04/20 and 03/06/20. Observation on 03/11/20 at 01:16 PM with Licensed Nurse (LN) H providing wound care to R86 revealed the sacrum pressure ulcer measurements obtained six centimeters (cm) by five cm by four cm. Interview with LN H on 03/12/20 at 10:20 AM revealed the dressing changes to R86 sacrum area with NPWT were moved from evening shift to day shift and said there was no order to measure the wound and there was no other documentation except for 03/09/20 when LN H measured the wound at six cm by five and a half cm by four cm. Interview with Administrative Nurse D on 03/12/20 at 11:29 AM revealed she expected the nurses to measure any wound weekly and document on the wound assessment sheets. Review of the Pressure Ulcer Prevention, Bruises, Skin Tears Procedure, dated 03/17, revealed no information was in the policy regarding the measurement of pressure ulcers. The facility failed to monitor/document improvement or decline regarding R86 pressure ulcer on the sacrum area for 18 days after R86's admission to the facility. - Review of R91's pertinent [DIAGNOSES REDACTED]. Review of the 03/03/20 Admission Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident required extensive two-person assistance for transfers and supervision with set-up for bed mobility. She had an unsteady gait with impairment to one side in her lower extremity (leg) and used a walker and wheelchair. She had one unstageable pressure ulcer with a noted deep tissue injury, and had pressure reducing bed/chair devices with pressure ulcer care. Review of the 03/03/20 Pressure Ulcer Care Area Assessment (CAA) revealed R91 admitted with a skin injury and an unstageable pressure ulcer area on her left posterior (backside) heel. This area had thick dry eschar (scab) with softening at edges and a light amount of brown drainage the staff treated with offloading. The right posterior heel had an area of suspected deep tissue injury (SDTI, tissue injury to deeper layers of the skin), with dry and sloughing (shedding) skin on her heel and foot. Review of 02/25/20 Baseline Care Plan revealed R91 noted with bilateral heel pressure ulcers and callouses, with anti-pressure boots to be worn at all times. Review of 02/2020 Pressure Ulcer Care Plan revealed R91 had a history of [REDACTED]. Review of Physician order [REDACTED]. to produce or respond to the hormone [MED] is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine) on Monday 6AM-2PM shift, Thursday 2PM-10PM shift. 02/25/20 Staff to complete weekly skin assessment on 2PM-10PM shift Tuesday. 02/27/20 R91 to wear anti-pressure boots to bilateral lower extremities at all times every shift. 02/27/20 Staff to cover bilateral heels with [MEDICATION NAME] (topical antiseptic) to wound base, cover with absorbent dressing (ABD) with hole, wrap with kerlix (gauze dressing) change daily and as needed. Review of 02/26/20 Skin Monitoring Comprehensive Skin Review noted pressure ulcers to the resident's bilateral (both) heels. Review of 02/26/20 Skin Monitoring Comprehensive Review revealed pressure ulcers to bilateral heels with treatment in place. Review of February 2020 to March 2020 2019 Colonial Wound Logbook revealed no documentation for the bilateral pressure wounds. Requested wound care and monitoring and Braden Assessment on 03/16/20 at 09:16 AM, did not receive documentation. Observation of R91 on 03/09/20 at 02:33 PM revealed her legs/heels were resting on the bed, dressings in place. Observation of R91 on 03/11/20 at 08:32 AM revealed the resident was dressed, wearing personal socks with no shoes, propelling in wheelchair to room. At 08:37 AM, the staff placed anti-pressure boots on the resident while the surveyor observed. Observation of R91 on 03/16/20 at 10:06 AM revealed after the surveyor requested to see the bilateral heel pressure wounds, Licensed Nurse (LN) K gathered the supplies, unwrapped old dressings from one heel at a time. The left heel measured 5 centimeters (cm) by 3.5 cm, with an intact black eschar well adhered, covered with pad and gauze, no [MEDICATION NAME] applied. The right heel had an intact brown/black eschar that was lifting at the edges, measured 2.5 cm by 2.5 cm. There wounds noted with some blanchable redness to the edges of both eschars. Interview with R91 on 03/09/20 02:33 PM revealed she had pressure ulcers to both heels and was supposed to have her legs elevated/anti-pressure boots in place but did not at the time of the interview. Both R91's heels were resting on the bed, dressings in place. Interview with Certified Nurse Adie (CNA) AA on 03/09/20 at 02:36 PM revealed the staff were to ensure R91's heels were elevated or the anti-pressure boots applied to resident when in bed. CNA AA did not know why those interventions were not implemented. Interview with Certified Nurse Aide Z on 03/16/20 09:58 AM revealed R91 had the anti-pressure boots to protect her heels when she was in bed. Interview with LNK on 03/16/20 09:41 AM revealed she needed to have her feet in the anti-pressure boots at all times. The wound nurses, and Administrative Nurse D measured and charted the wounds. LN K said she did not usually do the wound care changes and did not know about the application of [MEDICATION NAME] as part of the wound care. Interview on 03/12/20 at 11:29 AM with Administrative Nurse D revealed that Administrative Nurse Y took care of the wound documentation. She expected staff to follow the process with any new resident admitted with pressure ulcers. The residents would have the wound report/pressure report form filled out, and these forms were also in each house for the charge nurse to document if they see something. If the resident came into the facility from the hospital, she expected staff to document on the admission sheet as well start the wound sheet that would indicate the location of the wounds and the stage. She expected the wounds to be observed, measured, the risk factors noted, and notification that the nurse would check the wounds. She also expected the nurse to complete a weekly wound assessment, and those assessments were logged monthly. Wounds should be a measurement weekly with the assessment that would be placed in a monthly log sheet book. The wound documentation was not available to staff or physician, it was found locked in a notebook in the Assistant Director of Nursing's Office. The book should not be locked in the office, and dressing should be applied

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) per the physician order. She would also have expected anti-pressure boots to be in place per the physician recommendation, all the time, every shift when the resident was in bed. Review of 03/2017 Pressure Ulcer Prevention, Bruises, Skin Tear Procedure policy revealed the CNA will complete the head to toe skin check during bathing, notify Nurse with the area of concern. The nurse will assess and complete investigation if indicated. Nurse will document in resident's file and notify DON, physician and family. There is no information on procedure for documenting and care for pressure ulcers. The facility failed to ensure the resident had appropriate offloading and wound documentation which can result in the worsening of pressure ulcers.
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** The facility census totaled 92 residents with 21 residents in the sample and one resident reviewed for accidents. Based on observation, interview, and record review the facility failed to complete fall investigations and did not determine the causal factors of the falls to determine and implement appropriate interventions, including increased supervision, to reduce resident (R)75's risk for further falls. Finding included: - Review of R75 pertinent [DIAGNOSES REDACTED]. Review of the 02/21/20 Quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) of four, indicating severely impaired cognition. The resident required limited one-person assistance for transfers and was not steady while ambulating with her walker. She had two falls coded as occurring during the three-month review period. Review of the Falls Care Area Assessment (CAA) dated 11/26/19 revealed R75 was at risk for falls, she ambulated with a walker and required cues and reminders to use the walker. She had an unsteady stance and turning gait, and visual hallucinations which increased her risk for falls. Review of R75's Cognitive Loss Care Plan, last revised 12/06/19, revealed the resident had cognitive loss/impairment and directed the staff to encourage the resident to use her walker and ensure she had on proper footwear. Review of Fall Risk Assessments dated 12/24/19, 01/12/20, 01/29/20, 02/22/20 revealed resident high risk for falls. Review of the Activities of Daily Living Care Plan (ADL), last revised on 12/06/19, directed the staff to: 1. Remind the resident to use her walker. 2. Provide supervision/limited assist for bed mobility, transfers, walking, toileting as needed for safety. 3. A walker had recently been added for my safety. 4. Analyze falls to determine pattern/trend. 5. Assist in minimizing clutter in the immediate environment. 6. Assure eyeglasses are clean and in good repair. 7. Fall risk assessment on admission, quarterly, and as needed. 8. Keep call light in reach at all times. Remind her to use the call light as needed 9. Keep personal and frequently used items within reach. 10. Leave night light on in room. 11. Utilize Physical and Occupational Therapy as needed. 12. Orient her when there has been new furniture placement or other changes in environment. 13. Provide proper, well-maintained footwear. The care plan above revealed no updates/revisions since 12/06/19. Review of November 2019 to March 2020 fall investigations revealed R78 experienced falls on the following seven dates (with no care plan revisions noted): 1. 11/19/19 2. 12/24/19 3. 12/26/19 4. 01/12/20 5. 01/29/20 6. 02/22/20 7. 02/27/20 Review of Staff Communication Level of Function dated 12/10/19 revealed R75 required a front wheeled walker (FWW) for ambulation with staff supervision, required frequent visual checks especially if bathroom door was closed, and she received restorative nursing services. 1. The Fall Investigation dated 11/19/19 at 05:20 PM revealed the resident had a witnessed fall in the hallway. R75 attempted to hug another resident and fell . Staff had documented the resident used her walker at the time of the fall. Causal factors were identified as R75 not utilizing her walker and the new environment. The facilitys staff were advised to redirect the resident and remind her to use her walker. The causal factor and interventions do not match with the documentation of the resident using her walker when she fell . 2. The Fall Investigation dated 12/24/19 at 07:00 PM revealed the resident had an unwitnessed fall in her room ambulating with walker to her chair without assistance. Causal factor identified was the resident was ambulating without assistance of staff. Interventions that were indicated as appropriate were to assist the resident to toilet after every evening meal, ensure assistance provided for changing into night clothes, and consult a cardiologist for chest pain. On review of the Treatment Administration Record (TAR) for December 2019 revealed facility staff were to obtain orthostatic (used to check for decrease in blood pressure when changing position) blood pressure readings for four days after the fall, but only two of the days were completed. 3. The Fall Investigation dated 12/26/19 at 11:15 AM revealed the resident had an unwitnessed fall in her room due to loosing her balance while walking independently between her bed and chair. There is no mention if the walker was in use. Causal factors included the residents need for staff supervision when transferring and walking. Interventions were to obtain orthostatic blood pressures for three days and a chest X-Ray. The interventions placed did not match the causal factors identified. 4. The Fall Investigation dated 01/12/20 at 05:50 AM revealed the resident had an unwitnessed fall in room because she lost her balance while self-ambulating to the bathroom wearing only socks. The facility staff identified the resident's walker not being within reach as the causal factor. Their interventions included keeping the resident's walker within reach. The investigation was not completed to know if the resident had been using the walker during the fall so unknown if appropriate intervention. 5. The Fall Investigation dated 01/29/20 at 09:00 PM revealed the resident had an unwitnessed fall in her room while self-ambulating. She was found sitting on buttocks behind the door to the hallway. She did obtain a laceration (cut) to the back of the head measuring 5 centimeters (cm) by 0.1 cm. The causal factor identified with the fall was the amount of assistance the resident required and a medication change, however the intervention staff implemented to aide with prevention of further falls was neurological checks. There was no intervention listed which addressed the identified causal factor of the resident needing assistance. 6. The Fall Investigation dated 02/22/20 at 07:00 PM revealed the resident had an unwitnessed fall in her room while ambulating without walker. The causal factors were determined to be that the resident's door was closed, medication changes, and the resident not using the call light. Intervention identified was to ensure the door remained open while the resident was in the room. 7. The Fall Investigation dated 02/27/20 at 01:15 PM revealed the resident had and unwitnessed fall in her room while ambulating and lost her balance. Staff identified the causal factor as being walker at her side and supervision with transfers. Interventions were to ensure the room door remained open, which was the same as the 02/22/20 fall intervention. This intervention does not address the identified causal factor. Observation of R75 on 03/12/20 at 09:54 AM revealed the resident ambulated independently without her walker in the hall from her room to the dining room. Dietary Aide CC helped R75 set down in a chair in the dining area. She then tried to locate staff and eventually located an activity assistant to assist the resident. Interview with Certified Nursing Aide (CNA) Z on 03/16/20 at 09:58 AM revealed she always observes R75 up and moving and she tried to intercept when she observed that. She assumed the resident was toileted every two hours. Staff completed visual checks every 20 minutes, but did not chart/document it. Interview with Licensed Nurse K on 03/16/20 at 09:41 AM revealed the staff completed visual checks every 30 minutes or so, but did not chart or document the visual checks. The fall investigations were expected to be filled out completely and accurately. The nurses completed a resident fall assessment for every fall. Interview with Administrative Nurse D on 03/12/20 12:54 PM revealed if the fall investigations were not completely filled out, she looked at the charting for the missing information so that it could be completed. A new, appropriate intervention would be put in place according to why the resident fell . When administrative staff were notified of the falls, went over the fall investigations, the causal factors and interventions within a week, but stated we do not change/update the information. Review of 03/2017 Falls and Fall Prevention policy revealed the plan of care was reviewed to ensure the interventions are documented, resident specific, and appropriate follow-up is occurring. Causal factor analysis is part of the administrative review utilizing the five Why's to determine potential cause of fall. Use of information from the fall investigations, witness statements, resident interviews, chart review and actual fall site review with staff and resident would be used to formulate the causal factor. Administrative staff will review the incident and determine all documentation was done per policy and all interventions have been put into place and are being followed. The facility failed to complete fall investigations and did not determine the causal factors of the falls to determine and implement appropriate interventions to reduce R75's risk for further falls.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 92 residents (R) with 21 residents in the sample. Based on observation, interview, and record

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) review the facility failed to provide incontinence care to include a voiding diary for R46. Finding included: - Review of R46's pertinent [DIAGNOSES REDACTED]. fibrillation (an irregular and often rapid heart rate), and generalized muscle weakness. Review of the 08/05/19 Admission Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The resident did not reject care during the review period. R46 required extensive two-person assistance for toileting. She did not have a steady gait and used a wheelchair for mobility. Review of the 01/22/20 Quarterly MDS revealed a BIMS of 15, indicating intact cognition. The resident did not reject care during the review period. The resident required extensive two-person assistance for toileting. She did not have a steady gait and used a wheelchair. Review of the 08/05/19 Urinary Care Area Assessment (CAA) revealed R46 told staff she wore adult briefs and just goes into her brief and then staff changed her brief. The CAA noted the resident with some sensory awareness of the urges, and noted she needed assistance with meeting her toileting and hygiene needs. R46 worked with therapy with hopes of the ability to toilet. Review of revised 08/07/19 ADL Care Plan revealed R46's level of assistance with toileting could vary; the staff were to provide the level of assistance necessary for safety. Review of revised 08/07/19 Urinary Care Plan revealed as R46 regained strength, staff were to encourage her to alert staff prior to voiding, so she could try a toileting program. Staff were to provide incontinence care after each incontinence episode and apply a moisture barrier to her skin as needed. The toileting program was not specified, the medical record lacked evidence of a completed toileting diary, and the facility did not provide evidence of a toileting dairy as requested on 03/11/20 at 10:38 AM. Review of 08/06/19-11/27/19 OT Discharge Summary and 07/25/19-11/27/19 PT Discharge Summary revealed no indicator of how many times a week the CNA's were to work with resident for toileting. Review of March 10th, 2020 to March 16th, 2020 ADL report toilet use daily CNA charting revealed: 03/10/20 documentation lacked evidence toileting occurred. 03/11/20 documentation noted toileting occurred three times this day. 03/12/20 documentation lacked evidence toileting occurred. 03/13/20 documentation noted toileting occurred twice this day. 03/14/20 documentation noted toileting only occurred once this day. 03/15/20 documentation noted toileting occurred once this day. 03/16/20 documentation lacked evidence toileting occurred. Observation of R46 on 03/12/20 at 10:27 AM revealed CNA T in the resident's room to check and change the residents brief. The surveyor observed the resident's peri-area as red, and the resident stated, it hurts and burns. Barrier cream was applied to the resident's peri-area and a new brief placed while this surveyor observed. Interview with CNA T on 03/11/20 at 09:57AM revealed when she was trained on the floor, any non-ambulatory residents were encouraged to wear briefs, and then staff were so busy with the ones that needed to get up to the restroom that staff would have get to the resident's that wore briefs when they could to change them. Staff were to check and change R46 every two hours and provide peri-care as needed with the changes. Interview with Physical Therapy Assistant X on 03/11/20 at 12:45 PM revealed the CNA's were instructed to provide encouragement to R46 for toileting, such as trying to encourage R46 to use the commode instead of the brief. The CNA's charted those tasks in the kiosk. Interview with Administrative Nurse D on 03/11/20 at 01:10 PM revealed the CNA's charting for toileting was to be documented. The facility would not encourage non-ambulatory residents to wear briefs instead of toileting. If a resident needed toileted, they should be toileted, the facility would never say that if they are non-ambulatory, they have to wear a brief. Interview with Licensed Nurse E on 03/12/20 at 10:06 AM revealed the resident should be toileted every two hours. The staff should be doing these things, but we are down a staff member so the Certified Medication Aide (CMA) and CNA are working towards it. Interview on 03/12/20 at 10:27 AM CNA T stated R46 had protective skin cream that should have been put on her peri-area during the resident's last check and change, none was noted during brief change. CNA T stated, it would be obvious if the barrier cream was there, it was not applied last check-n-change. Interview with LN K on 03/16/20 at 09:41 AM revealed the CNA's assisted with toileting and document it. Interview with Administrative Nurse D on 03/17/20 at 11:00 AM revealed she would expect the charting for check-n-change/toileting should be in the care tracker (Cerner). She would expect the CNA's to put protective barrier cream on a resident's peri-area that required it, if the skin was irritated or if the resident was at risk for incontinence and toileting should be completed specific to the resident need. The facility failed to provide a policy regarding toileting as requested on 03/16/20 at 10:00AM. The facility failed to provide the incontinence care appropriately for R46 resulting in skin irritation.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 92 residents with 21 residents included in the sample and one resident sampled for oxygen use. Based on observation, interview, and record review the facility failed to maintain supplemental oxygen supplies when they did not replace Resident (R) 78's outdated oxygen tubing and humidifier container. Findings included: - Review of the Annual Minimum Data Set (MDS) for R78, dated 02/20/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R78 with shortness of breath, [MEDICAL CONDITION], and supplemental oxygen. Review of the Care Plan revised 02/20/20 lacked instructions and/or interventions regarding the use of supplemental oxygen. Review of R78's Treatment Administration Record (TAR) and Medication Administration Record [REDACTED]. An observation on 03/09/20 at 05:22 PM revealed R78 sat in her wheelchair visiting with family in her room, with oxygen tubing on. Observation revealed the oxygen tubing contained a date of 03/01/20 and the humidifier on the concentrator was dated 02/01/20. An interview on 03/11/20 at 10:16 AM with Certified Medication Aid (CMA) R stated oxygen tubing and humidifiers were changed every week on Sunday nights and documented on the TAR. An interview on 03/11/20 at 10:19 AM with Licensed Nurse (LN) L stated staff changed the oxygen tubing and humidifiers weekly and as needed. LN L confirmed oxygen tubing and humidifier were outdated. An interview on 03/16/20 at 10:11 AM with LN K stated she expected supplemental oxygen use to be on the care plan and reported that Administrative Nurse D or other Registered Nurses (RN's) updated the care plan. An interview on 03/12/20 at 12:54 PM with Administrative Nurse D stated the dates of 03/01/20 on R78's oxygen tubing and 02/01/20 on the humidifier container were unacceptable and were both outdated. Although requested on 03/16/20, the facility did not provide a policy regarding the use of supplemental oxygen. The facility failed to maintain supplemental oxygen supplies when they did not replace R78's outdated oxygen tubing and humidifier container.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** The facility had a census of 92 residents in 5 neighborhoods. Based on observation, interview and record review, the facility failed to have enough nursing staff available on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. Findings included: - Review of the Nurses Staffing Schedule from 02/01/20 through 03/11/20 showed: All five neighborhoods were to staff one Licensed Nurse (LN), one Certified Medication Aide (CMA) and two Certified Nursing Aides (CNA) on day and evening shifts. There facility reported staffing one LN and one CNA on the night shift. The facility lacked documentation of daily sheets recording who worked in what neighborhood and if neighborhoods were missing staff such as call-ins or open shifts. Review of the Long-Term Care Self-Assessment, dated 03/09/20, revealed all neighborhoods required one Licensed Nurse, one Certified medication Aide, and 2 Certified Nursing Assistants on day and evening shifts. On night shift one Licensed nurse and one CNA to provide adequate care for the 92 in-house residents. Staffing levels confirmed by Administrative Staff B. Review of Resident Council Minutes from January 2020 to March 2020, revealed on 01/02/20 the residents expressed concerns that CNAs were pulled too often in the federal house causing call light issues. On 02/06/20, the residents reported continued staff shortage and that pagers were not being carried by the staff who were present. The 03/05/20 resident council meeting revealed the residents still had concerns about staff shortages. Observation on the Colonial Neighborhood 03/12/20 at 07:30 AM revealed staffing of one LN, one CMA, and one CNA. The staffing was one CNA short-- based on the monthly staffing schedule listed above. Observation of Resident (R) 75 on 03/12/20 at 09:54 AM revealed the resident ambulating independently without a walker in the hall to the dining room, Dietary Staff CC was in the kitchen doing chores, and noted the resident and helped her sit down in a chair in the dining area. Dietary staff CC went down the hall to find nursing staff and was unable to locate either a CNA, LN, or CMA. She was able to alert an activity aide and assisted the resident to the activity. Observation on 03/12/20 at 10:27 AM CNA T was in the resident's room to provide toileting assistance to R 46, When brief removed the resident's peri-area was red, the resident stated it hurt and burned. The CNA said she had cream that should have been put on the peri area though no cream visible on the tissues. CNA T stated it would be obvious if it was there, it was not applied. Last night there was only one CNA on Colonial because they had to move the other one upstairs to Federal, so I imagine on 6AM didn't get changed at all.

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) CNA T applied the ordered cream to the peri-area and a new brief put on. Observation of the staff on duty on the 6AM-2PM shift on 03/12/20 revealed: Colonial -one LN, one CMA, one CNA Craftsman- one LN, one CMA, one CNA Federal- one LN, one CMA and two CNA Victorian- one LN, one CMA, one CNA Rapid- one LN, 1 CMA, 2 CNA Observation of staffing on 03/16/20 on the 6AM-2PM shift revealed: Colonial one LN, one CMA, one CNA Craftsman- LN (working as LN on Federal and Craftsman) and one CNA Federal- LN, two CNA, and one CMA. Victorian- one LN, one CMA, two CNA Observation on 03/16/20 at 8:30 AM on Craftsman neighborhood revealed sampled residents: R143, R45, R92, R61 and R56 revealed all the residents listed were in bed sleeping with no staff in the rooms getting residents ready for breakfast. Observation on 03/16/20 08:33 AM Homemaker HH reported no residents had been served breakfast yet. She reported she went down the hall but could not find a staff member and all residents were still in bed. Observation on 03/16/20 08:39 AM revealed CNA II entered onto the hall and confirmed she was the only aide working this hall today and verified no residents were up yet. During an interview on 03/12/20 at 11:00 AM a confidential interview with a family member revealed she had to come and take care of the resident because there was not enough staff to do it. She had not complained in fear of her resident not getting care if she did. During an interview on 03/11/20 at 09:57AM CNA T revealed when she was trained, any non-ambulatory residents were encouraged to wear briefs, and then we were so busy with the ones that needed to get up to the restroom that we would get to them when we could. We have two CNAs for the Colonial Hall, and if they were both here, we had a routine and could get everyone changed, turned, toileted all that, but otherwise it was a hectic day. During an interview on 03/12/20 08:19 AM CNA FF reported that she felt if no staff called in, they could manage the residents needs. CNA FF said if there was a call- in, then we had to have the nurse work the floor with me or wait for a replacement if there was one. During an interview on 03/12/20 at 08:22 AM CNA EE reported she thought staff was ok. She was new and had only worked this hall a couple of times and it had been okay during those times because the CMA and Nurse helped. During an interview on 03/12/20 at 09:00 AM CMA S reported no, there was not enough staff. She was the CMA and did some treatments and when they were short, she had to try to do it all--get medications passed and treatments done and still assist in getting the residents up and provide care. CMA S said some days it was just too much. CMA S said today there was just one CNA and she was new, so the nurse and herself were working to care for the residents and teach the new staff at the same time. During an interview on 03/12/20 08:24 AM LN I reported if they had the scheduled amount of staff they could provide the care for the residents, but when there was a call in, which LN I said happens more lately they usually, they had to pull the medication aide or all work the floor until a replacement was found. LN I said the facility had a lot of new CNAs that needed to be trained on the proper way to care for the residents. LN I said the staff made it work, but it was not ideal. Today there was just one aide on duty and so the CMA and charge nurse must work the floor to care for the residents. During an interview on 03/16/20 08:19 AM LN J reported they often work short of staff but not usually this short. She reported she was the licensed nurse for both upstairs households and only had 1 CNA to get people up. LN J stated most residents were still in bed. During an interview on 03/16/20 at 08:50 AM CMA GG reported she was from another unit and she passed medications on her unit then they pulled her to pass medications on this hall. During an interview on 03/12/20 at 03:14 PM Scheduling Staff W reported they do not track which staff works in each house. She had a schedule for every two weeks which displayed the staff scheduled, but did not track call-ins to know who was working or which units were short on staff. During an interview on 03/16/2020 at 09:30 AM Administrative Nurse A reported the scheduler did the schedule then for open shifts she puts staff in if they could work, but stated they did not go back and update the schedule for who did not come in. Administrative Nurse A said the facility did not write out staffing sheets for the neighborhoods. Administrative Nurse A said if a neighborhood was short on staff we tried to replace and pull staff from other neighborhoods to work. The facility did not provide a policyregarding staffing as requested on 03/16/20. The facility failed to have enough nursing staff available on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 92 residents with three of six medication storage rooms reviewed. Based on observation, interview, and record review the facility failed to properly label opened medications and failed to discard medications after the expiration or use by date. Findings included: - The medication storage/labeling tour began on [DATE] at 10:55 AM with the medication storage room in the Victorian House revealed one open bottle of TUMS (over the counter medication used to treat symptoms caused by too much stomach acid) without an open date. Review of the Federal House medication storage room on [DATE] at 09:41 AM revealed the following outdated or improperly labeled medications: [REDACTED]. 2. [MEDICATION NAME]pen, opened with no open or discard date for R51. 3. One opened [MEDICATION NAME] pen with no open or discard date and no name. 4. One opened Lemire [MED] pen with no open or discard date and no name. 5. One open vial of [MEDICATION NAME] in the medication refrigerator, dated [DATE]. An interview on [DATE] at 09:47 AM with Licensed Nurse (LN) JJ stated he discarded outdated medications and labeled [MED] pens with the open date and resident's name. LN JJ verified all four [MED] pens were not labeled properly and verified the open vial of [MEDICATION NAME] as outdated. LN JJ reported [MEDICATION NAME] expired 30 days after opening, and the [MED] pens needed discarded due to lack of a label. An interview on [DATE] at 09:16 AM with Administrative Nurse D stated [MED] pens were labeled with the date and name when opened and were discarded when unlabeled. Administrative Nurse D stated she expected nursing staff to review medication storage rooms daily, if not weekly, and discard outdated and unlabeled medications. The facility's policy titled, Medication Administration, revised ,[DATE] lacked information or instruction regarding medication labeling and/or storage. Although requested on [DATE], the facility did not provide a policy for medication labeling and storage. The facility failed to properly label opened medications and failed to discard medications after the expiration or use by date.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 92 residents with one main kitchen and satellite refrigerators located in other units of the facility which contained nutritional items for residents. Based on observation, interview, and record review the facility failed to store food in a sanitary manner through the lack of open dates on stored foods and the storage of expired foods. The facility failed to provide appropriate levels of sanitation by lack of monitoring of the chlorine level and failed to serve residents in a sanitary manner by the lack handwashing/ hand sanitizer prior to handling food items directly. Findings included: - Review of the refrigerator in the main building on [DATE] at 01:39 PM revealed the following food items stored in the refrigerator: an opened sleeve of sliced American cheese with no open date on the package, a opened bag of pepper jack cubed cheese with no open date on the package, and an opened bag of mozzarella shredded cheese with no open date. Further review of the refrigerator indicated a jar of pepperoncini marked open on ,[DATE] with an expiration date of ,[DATE] remained in the refrigerator. A jar of pickled okra opened on ,[DATE] with a discard date of ,[DATE] remained in the refrigerator. Observation of the kitchen on the Rapid Recovery unit on [DATE] at 02:30 PM revealed a mini pizza in a plastic bag opened with no open date and a hotdog in an opened plastic bag with no date and ice crystals built up on the hotdog. Review of policy Food and Supple Storage dated ,[DATE] revealed all food non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of food for human consumption. Cover, label and date unused portions and open packages, and noted the use of a label to be filled out fully and would indicate the products were good through the close of business on the date noted on the label. The facility failed to store food in a sanitary condition by not dating food items when opened or by lack of discarding outdated food items. - Observation of the dishwashing process on [DATE] at 01:59 PM Dietary Staff DD tested the chlorine level, which indicated the chlorine level was below the acceptable level of 100 parts per minute (ppm) required to sanitize dishes. A review of the test strips revealed the strips expired in 2017. Dietary Manager (DM) BB obtained new strips to test the chlorine level, which did not register appropriately. DM BB shut down the dishwasher and activated the three-sink process to ensure the sanitization of dishware. The observed sanitation log for chlorine from [DATE] to [DATE] indicated

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 9) chlorine level at 100 parts per minute (ppm) showed the appropriate chlorine level. Observation on [DATE] at 02:30 PM dishwasher chlorine level tested after repair of the dishwasher revealed appropriate chlorine level for sanitation. Interview with Dietary Manager BB on [DATE] at 01:59 PM revealed DM BB was not aware the dishwasher sanitation chlorine was not working correctly. Review of policy Leadership Interrelationship of Qualified Dietician and Director of Dining, reviewed ,[DATE], revealed the LD services will include but will not be limited to operation, budget menu planning, and quality competency, and other parameters to ensure efficiency and effectiveness of the functions of food and nutrition services. The facility failed to maintain adequate sanitation levels of the dishwasher chemicals from [DATE] to [DATE]. - An observation on [DATE] at 05:09 PM revealed Certified Nurse Aide (CNA) P cut a Rueben sandwich for a resident. CNA P did not wash her hands or use hand sanitizer before handling the resident's sandwich with her bare hands. During an interview on [DATE] at 09:06 AM with Administrative Nurse D revealed she expected staff to use appropriate hand hygiene and never handle a resident's food with bare hands. Review of Handwashing and Glove Use policy dated ,[DATE] revealed handwashing is the single most important measure to reduce the risks of transmitting microorganisms. The facility failed to serve residents in a sanitary manner by failing to follow standards of practice when a CNA touched a resident's food with her bare hands and had not washed her hands or used hand sanitizer prior to handling the food directly.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** The facility total census totaled 92 residents with 21 residents in sample. Based on interview and observation, the facility failed to ensure the pressure ulcer measurements book were readily accessible for three of three residents (R) sampled for pressure ulcers. (R66, R86, and R91) Findings included: - On 03/12/20 at 11:29 AM surveyors were advised the pressure ulcer measurements were unavailable for the staff due to the logbook in which the measurements were recorded, were secured in an office of a staff member who left on vacation. Interview with Administrative Nurse D on 03/12/20 at 11:29 AM revealed she expected the logbook to be accessible for staff at all timse. The facility failed to provide a policy, as requested on 03/16/20, for medical records accessibility. The facility failed to ensure R66, R86, and R91's complete medical record were accessible to the staff by the failure to have the wound measurements book readily accessible.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** The facility identified a census of 92 residents. Based on observation, interview, and record review the facility failed to ensure adequate hand hygiene, infection surveillance on all units, prevention of potential cross-contamination and infection when direct care staff kept his/her personal drinks in resident care areas and in the medication cart, direct care staff did not follow contact precautions during cares, and laundry staff used a permeable gown to sort soiled linens. These failures had the ability to affect all residents in the facility. (Resident(R)143, R92, R61) Findings included: - An observation on 03/01/20 at 08:35 AM observed Certified Medication Aide (CMA) MM did not perform hand hygiene between resident rooms. An interview on 03/10/20 at 08:56 AM with CMA MM stated she used hand sanitizer once every three rooms. An interview on 03/16/20 at 09:16 AM with Administrative Nurse D stated staff must wash hands with soap and water before starting care and she expected staff to perform hand hygiene between contact with each resident. The facility's policy titled, Handwashing and Glove Use, dated 04/2008 documented, Wash hands between each resident, procedure, wounds, all body fluids, eating/drinking, coughing, hygiene, sneezing, etc. The policy instructed to used antiseptic towelette or hand cleaner where there was no immediate access to running water. The facility's policy titled, Infection Control, dated 01/2017 documented, KMH will require staff to wash their hands after each direct resident contact. The facility failed to ensure proper hand hygiene between contact with each resident. - An observation on 03/10/20 at 08:10 AM revealed Certified Medication Aid (CMA) MM in a resident's room and noted a personal drink on the cart she used to pass medications. An interview on 03/10/20 at 08:56 AM with CMA MM stated no one in the facility voiced any concerns that she had a personal drink on her medication cart. An interview on 03/16/20 at 09:16 AM with Administrative Nurse D stated it was unacceptable for staff to have personal drinks on medications carts and should not have personal drinks or items on carts, in halls, resident rooms, or near other resident care items. The facility's policy titled, Infection Control, dated 01/2017 documented that KMH followed national standards as established by the Centers for Disease Control and Centers for Medicare and Medicaid Services. The policy stated that the KMH Infection Control Program included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. The facility failed to ensure prevention of infection/cross-contamination when CMA MM had her personal drink in a resident's room, on the medication cart, and near resident care areas and items. - Review of the infection surveillance documentation revealed lack of tracking/trending infection monitoring and documentation for the Colonial, Craftsman, Federal, and Victorian houses for February 2020. An interview on 03/12/20 at 10:30 AM with Administrative Nurse D stated she expected tracking and trending to be completed for the month of February, but verified only the Rapid Recovery unit was completed and the other four units were not done, which included the Colonial, Craftsman, Federal, and Victorian houses. The facility's policy titled, Infection Control, dated 01/2017 documented the facility maintained infection control programs to prevent, investigate, and prevent infections in the facility, and maintained records of incidents and corrective actions related to infections. The facility failed to ensure infection surveillance when they did not track/trend infection monitoring in February 2020 for the Colonial, Craftsman, Federal, and Victorian houses. - Tour of the laundry began on 03/13/20 at 11:20 AM with Environmental Services Staff NN in the basement where laundry services occur. An observation on 03/13/20 at 11:20 AM of a thin, lightweight cloth gown hung from a wall just above a large open trash can, with the lower part of the gown observed directly in the trash can. An interview on 03/13/20 at 11:20 AM with Environmental Services Staff NN reported he used a very lightweight cloth gown with no water repellant abilities when handling soiled linens. The facility's policy titled, Infection Control, dated 01/2017 documented the facility handled, stored, processed, and transported linens to prevent the spread of infection. The policy lacked information and/or instruction regarding the use of Personal Protective Equipment (PPE) when handling soiled linens to prevent infections and/or cross-contamination. The facility's undated policy titled, Laundry K.A.R. 28-39-100(a), documented, Excessively soiled linens (those soiled by body excretions, feces, etc.) will be taken immediately to the soiled utility room and placed in the soiled linen hamper. The policy lacked information and/or instruction for proper PPE when handling soiled linens to prevent infections and/or cross-contamination. The facility failed to ensure prevention of infection/cross-contamination when they used a ensure the use of a non-permeable gown for sorting laundry sorting soiled linens and failed to prevent further infections/cross-contamination when the gown was allowed to hang into an open trash bin. - Observation on 03/09/2020 at 3:40 PM revealed Licensed Nurse (LN) H changed R143's dressing to the coccyx. The nurse had the resident roll to her left side and, with gloved hands, unfasten the residents brief. The resident had a bowel movement (BM), and the nurse used wet wiped to clean the area. LN H reached into the wet wipe container six times for more wipes, without changing her gloves from cleaning feces off the resident. The nurse then placed the clean brief under the resident. She then changed gloves and sanitized her hands. LN H then cleaned the wound with a wound cleaner reaching into the package of 4x4's several times with the same gloves. The wound was then measured, and the dressing applied with LN I wearing the same gloves. During an interview on 03/09/2020 at 03:45 PM LN I reported she should have changed her gloves more often. She had another nurse watching her do wound care and just did not change them as appropriate. During an interview on 3/16/2020 at 09:30 AM Administrative Nurse A reported all Licensed Nurses know the proper way to do wound care. She thought the nurse was nervous with a surveyor and another nurse watching her. That's no excure but thought that's what happened. Review of the Facility Policy named Handwashing and Gloving, dated 04/08, revealed wash hands between each resident, procedure wounds, all body fluid. Wash hands before and after removing gloves. The facility failed to provide an infection-free environment for R143 during the changing of a wound dressing. - Observation on 03/10/20 at 01:38 PM revealed Certified Nursing Aide' (CNA) R and CNA P placed a gait belt around R92 and then transferred her to bed. CNA R with gloved hands removed the residents brief and threw it and the wet wipes on the carpeted floor. The wet brief lay on the carpet at the end of the bed. During an interview on 03/10/2020 at 01:48 PM, CNA R reported she did not see a trash can, so she just

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175118	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KANSAS MASONIC HOME	**402 S MARTINSON STREET WICHITA, KS 67213**

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 10) threw the brief on the floor. Usually, she would put it in the trash can. During an interview on 03/10/2020 at 01:50 PM Licensed Nurse I reported the incident of the brief thrown to the floor was an infection control issue, and no brief should be thrown on the floor but disposed of in a plastic bag and placed in the trash. If the staff did not see a trash can, she needed to look for one. During an interview on 3/16/2020 at 09:30 AM Administrative Nurse A reported she expected nursig staff to know how to dispose of briefs properly. The staff are all in-serviced on the need for infection control. The facility failed to provide an infection-free environment for the R92 by throwing a soiled brief onto the carpeted floor during incontinent care. - Observation on 3/16/2020 at 08:40 AM LN J entered R 61 room after hearing the resident hollering for help. The nurse entered the room with no personal protective equipment (PPE) even though the resident was in contact precautions for VRE (antibiotic-resistant bacteria) in the urine. The resident was complaining about her incontinent brief, and LN J, without gloves, pulled the resident's covers back and proceeded to adjust the resident's brief so it would be more comfortable. After providing care, LN J washed her hands and left the room. During an interview on 3/16/2020 at 8:42 AM, LN J came out of the resident room and then realized she had not gowned and gloved before adjusting the residents brief. She then apologized and acknowledged she forgot PPE. During an interview on 3/16/2020 at 09:30 AM Administrative Nurse A reported she expected all staff especially Licensed Nurses to maintain precautions when a resident is in isolation. Review of the Facility Policy named Handwashing and Gloving, dated 04/08, revealed wash hands between each resident, procedure wounds, all body fluid. Wash hands before and after removing gloves. The facility failed to provide an infection-free environment for R61 through handling the brief of a resident in contact precautions with VRE in the urine, without the use of appropriate PPE.