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	175410	A. BUILDING _____ B. WING _____	02/27/2023

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CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations KS00174442, KS00174719, KS00175754, KS00176932 and KS00178016. The 2567 was electronically sent on 03/10/23.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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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§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 89 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to promote dignity during the dining experience for residents in two of three dining rooms when staff scraped off soiled plates next to residents who were still eating and nursing staff administered eye drops and nasal spray medications in the dining room in front of other residents. The facility further failed to ensure a dignity cover for R21's urinary drainage bag. This deficient practice placed residents at risk for impaired dignity and embarrassment.

Findings included:

- On 02/22/23 at 09:02 AM, while several residents were still eating, observation revealed Certified Medication Aide (CMA) R wheeled the garbage cart between dining tables, scraping off soiled plates within one foot of seated residents still dining.

On 02/22/23 at 12:40 PM, observation revealed Dietary Staff (DS) CC cleaned off tables with residents still sitting there. Continued observation

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revealed DS CC wheeled the garbage cart around the room, behind and beside residents, when he scraped off soiled plates.

The facility's "Resident Rights" policy, dated 2022, stated residents had the right to be treated with respect, kindness, and dignity.

The facility failed to promote dignity during the dining experience for residents in two of three dining rooms when staff scraped off soiled plates next to residents who were still eating, placing the residents at risk for a less than dignified dining experience.
- On 02/21/23 at 11:54 AM, during the noon meal, observation revealed Certified Medication Aide (CMA) M administered R50's eye drops at the dining room table, with several residents in the dining room, eating their noon meal and able to view the procedure.

On 02/21/23 12:19 PM, observation during the noon meal revealed CMA M administered R15's nasal spray at the dining room table with two other residents at her table and several other residents eating their meals in the dining room able to view the procedure.

On 02/22/23 at 08:18 AM, observation during the breakfast meal service revealed CMA M administered R50's nasal spray, at the dining room table, with six residents present and able to view the procedure.

On 02/22/23 at 08:21 AM, observation during the breakfast meal service revealed CMA M administered R50's eye drops at the dining room table with six residents present and able to view the procedure.

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Review of R15 and R50's care plans lacked documentation which indicated staff could administer the eye drops and nasal spray at the dining room table.

On 02/22/23 08:23 AM, CMA M stated it was care planned that staff could administer R15's nasal spray and R50's eye drops at the dining room table.

On 02/27/23 at 10:15 AM, Administrative Nurse D stated if staff needed to administer R15's nasal spray or R50's eye drops while they were seated at the dining room table, staff should remove them to their rooms and administer the medications there.

The facility's "Resident Rights Policy," revised 2022, documented all residents had the right to a dignified existence and should be treated with respect, kindness, and dignity.

The facility failed to treat R15 and R50 with dignity when staff administered R15's nasal spray and R50's eye drops at the dining room table with several other residents present. This placed them at risk for an undignified experience.
- R21's Electronic Medical Record (EMR) recorded diagnoses of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R21's "Quarterly Minimum Data Set" (MDS), dated 12/23/22, recorded the resident had a Brief

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Interview for Mental Status (BIMS) score of two (severely cognitively impaired), and an indwelling urinary catheter (a tube in the bladder to drain urine).

R21's "Care Plan," dated 12/23/22, recorded the resident had a suprapubic catheter (urinary catheter inserted into the bladder through the abdomen) for neurogenic bladder post back surgery. The care plan recorded staff were to flush the catheter per physician order and assist with drainage bag throughout the day. The care plan lacked any guidance for staff to cover the urinary catheter bag.

On 02/21/23 at 04:10 PM, observation revealed R21 rested in bed, with the uncovered urinary catheter bag hanging on the right side of the bed frame, visible from the hall.

On 02/22/23 at 08:00 AM, observation revealed R21 sitting up in bed, with the uncovered urinary catheter bag hanging on the right side of the bed frame, visible from the hall.

On 02/27/23 at 08:50 AM, Administrative Nurse F stated the resident's urinary catheter bag should be covered at all times.

The facility's "Resident Right" policy, 2022 (no month documented), documented the staff shall treat all residents with kindness respect and dignity. The policy documented Federal and State laws guarantee certain basic rights to all residents of this facility and theses rights include the resident's right to: a dignified existence, be treated with respect, kindness, and dignity.

The facility failed to cover R21's urinary catheter

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F 550	Continued From page 5 bag, placing the resident at risk for embarrassment and an undignified living environment.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		

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60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 89 residents. The sample included 18 residents. Based on record review and interview, the facility failed to provide three sampled residents, Resident (R)13, R38 and R189 (or their representative) the completed Skilled Nursing Facility Advanced Beneficiary Notices (ABN) form 10055, (CMS) Centers for Medicare and Medicare Services which placed them at risk to make uninformed decisions about their skilled care

Findings included:

- The Medicare ABN form 10055 informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an option for the beneficiary to receive specific services listed, and bill Medicare for an official decision on payment. The form stated 1) I

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understand if Medicare does not pay, I will be responsible for payment, but can make an appeal to Medicare, (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for services, (3) I do not want the listed services.

The facility failed to provide R13 the completed form 10055, which estimated the cost for the services to be able to make an informed choice whether the resident wanted to receive the items or services, knowing he/she may have to pay out of pocket. The resident's skilled services ended on 12/01/22.

The facility failed to provide R38 the completed form 10055, which estimated cost for the services to be able to make an informed choice whether the resident wanted to receive the items or services, knowing he/she may have to pay out of pocket. The resident's skilled nursing services ended on 02/01/23.

The facility failed to provide R189 the completed form 10055, which the estimated cost for the services to be able to make an informed choice whether the resident wanted to receive the items or services, knowing he/she may have to pay out of pocket. The resident's skilled nursing services ended on 11/28/22.

On 02/22/23 at 11:00 AM, Social Services X verified the facility staff had not provided the resident and/or their representative the CMS form 10055.

On 02/22/23 at 04:00 PM, Administrative Staff A verified the facility had not provided the resident and/or their representative the CMS 10055 form.

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F 582	Continued From page 8 Upon request the facility did not provide an Advance Beneficiary Notice of Non-Coverage policy. The facility failed to provide R13, R38, and R189, or their representatives, the completed ABN 10055 form when discharged from skilled care, which placed them at risk to make uninformed decisions about their skilled.	F 582		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		

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assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 89 residents. The sample included 18 residents with seven reviewed for accidents. Based on observation, interview, and record review the facility failed to review or revise the care plan to prevent further falls for Resident (R) 19 after three of her falls. This deficient practice placed R19 at risk for further falls and injury.

Findings included:

- R19's Electronic Medical Record (EMR) documented diagnoses of severe dementia (group of thinking and social symptoms that interferes with daily functioning), unsteadiness on feet, muscle weakness, and chronic pain.

The "Significant Change Minimum Data Set" (MDS), dated 01/07/23, documented a Brief Interview for Mental Status (BIMS) score of zero, and short- and long-term memory problems with severely impaired decision making. The MDS documented R19 required extensive assistance of one staff for eating, hygiene, extensive assistance of two staff for bed mobility, transfers, walking, locomotion, toileting, dressing and total assistance with bathing. The MDS documented R19 had impaired balance and unable to stabilized without help, no range of motion impairment, and used a wheelchair.

The "Fall Care Area Assessment" (CAA), dated 01/20/23, documented R19 was at risk for falls secondary to balance and gait issues with transitions and ambulation.

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The "Fall Care Plan," dated 01/17/23, documented R19 was at risk for falls secondary to balance, gait issues, ambulation, frequent falls, severe dementia, poor safety awareness, communication deficit, and potential medication side effects. The care plan directed staff to ensure R19 wore proper footwear prior to assisting her with transfers. The 03/20/2022 care plan update stated R19 was sent to the emergency room and received one staple to the back of her head. No further direction for staff for prevention of falls. The 06/19/2022 care plan update stated R19 was transported to the emergency room and returned with a new order for pain medication. No further direction for staff for prevention of falls. The 09/25/22 care plan update directed staff to perform frequent checks when R19 was in bed.

The "Progress Note," dated 03/20/22 at 0751 AM, documented staff found R19 on the floor in her bathroom, seated upright with her feet and legs positioned in front of her, wearing tennis shoes. There was a splatter of blood on the bathroom floor behind her and a scant amount of blood was visible on the back of the resident's head. The physician order staff to send to R19 to the hospital.

The "Progress Note," dated 06/19/22 at 07:40 PM, documented R19 fell and hit her head, but did not lose consciousness per staff report. The note stated R19 had a medium sized hematoma (bruise with swelling) on the back of her head with a 3-centimeter (cm) purple/black line imprinted in it. Swelling and redness was also noted to outer area of purple line from hitting the door frame. R19 sent to the hospital via emergency services.

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The "Progress Note," dated 06/20/2022 07:40 PM, stated the root cause of R19's fall was severe dementia; R19 walked around the neighborhood constantly, and lost her balance. The intervention would be a therapy screen.

The "Progress Note," dated 09/02/22 at 03:02 PM, R19 was found by staff in her own room but on the other side where she has a roommate, lying on her back. The fall was unwitnessed, neurological checks were started and were at baseline for the resident. The note directed staff would assist the resident in taking a rest break after breakfast and lunch. This was not noted on R19's plan of care.

The "Progress Note," dated 09/25/22 at 03:35 PM, staff found R19 on the floor in her room, on her back right next to her bed and a pile of covers. Upon assessment resident did not appear to be in any pain; her pupils were equal round reactive to light, hand grasps equal and strong. She had no bruising to her back or buttocks, and did not appear to have hit her head. Since the fall was not witnessed, proceeded with neurological checks as a precaution and they were at baseline. The note stated the nurse encouraged staff to perform frequent visual checks when the resident was resting in bed since she was prone to getting up and out of bed on her own. The note recorded the root cause was R19 was tangled in blankets and directed frequent checks when R19 was in bed, but did not specifify frequency.

The "Progress Note," dated 12/26/22 at 05:58 AM, documented staff found R19 on the floor in her room with her head resting on her bed rail with no visible injuries noted. The note

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documented staff notified her physician via fax and requested an order for non-skid socks while in bed due to the resident ambulated at will and had poor safety awareness due to dementia.

On 02/22/23 at 07:45 AM, observation revealed Certified Nurse Aide (CNA) O and Certified Medication Aide (CMA) S used the total lift to transfer R19 from her bed to her wheelchair. R19 spoke unintelligible words, but when asked if she had pain, R19 replied "No." Further observation revealed deep purple bruising to the upper back of R19's right arm, with yellowing bruising to the distal upper arm. When staff dressed R19, staff was gentle with R19's right arm, but she still clenched her teeth. When staff brought R19 out to the dining room, she had a sling on her right arm.

On 02/27/23 at 08:50 AM, Administrative Nurse D verified the care plan had not been updated after each fall and verified the lack of pertinent, effective and measurable fall prevention interventions.

The facility's "Managing Falls and Fall Risk" policy, dated 2022, stated based on previous evaluations and current data staff would identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling or try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remained relevant.

The facility failed to review or revise R19's care plan to prevent further falls, placing R19 at risk for further falls or injury.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 89 residents. The sample included 18 residents with six residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide necessary services to maintain good personal hygiene, including bathing for one of the six reviewed for ADLs, Resident (R)33. This placed the resident at risk for poor personal hygiene and infection. Findings included: - R33's Electronic Medical Record (EMR) recorded diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), diabetes mellites (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and muscle weakness. R33's "Quarterly Minimum Data Set " (MDS), dated 11/14/22, recorded R33 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognition impairment. The MDS recorded R33 required extensive assistance of one staff for most activities of daily living and bathing. The "Activities of Daily Living Care Plan," dated 01/09/23 indicated the R33 required assistance with ADL care. The care plan recorded the	F 677		

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resident required extensive assistance of one staff with bathing and personal hygiene. The care plan lacked frequency or days of bathing.

R33's "Skin Integrity; Shower/Bathing Review" documented the resident received a bath twice a week.

The "December Bathing Report" documented the resident received a bath on the following days:
12/03/22
12/07/22
12/10/22
12/14/22
12/17/22

The resident refused the following dates:
12/21/22
12/24/22
12/28/22
12/31/22
01/04/23
01/07/23

The "January Bathing Report" documented the resident received a bath/shower on the following days:
01/11/23 (25 days no bath/shower)
01/14/23
01/17/23
01/18/23
01/21/23
01/25/23
01/28/23

On 02/21/22 at 03:55 PM, observation revealed R33 sat in a wheelchair in her room with the bedside tablet in front of her. Continued observation revealed the resident's hair appeared

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F 677	Continued From page 15 uncombed and greasy. On 02/27/22 at 10:00 AM, Administrative Nurse D verified the residents have scheduled bath/shower days and the aides document on shower sheets; if the resident refused, the aides would inform the charge nurse who would talk to the resident and document in the electronic health record the resident reason for refusal. The facility's "Activities of Daily Living (ADLs)" policy, dated 2022 (no month documented), recorded the residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services would be provided for residents who are unable to carry out ADLs independently, with the onset of the resident who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care , including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care); mobility (transfer and ambulation, including walking); elimination (toileting); dining (meals and snacks); and communication (speech, language, and any functional communication systems). The facility failed to provide the necessary care and bathing services for R33, placing the resident at risk for poor hygiene.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 89 residents. The sample included 18 residents with seven reviewed for accidents. Based on observation, interview, and record review the facility failed to identify and implement meaningful, resident-centered interventions to prevent falls for Resident (R) 19 and failed to complete ongoing monitoring for fall related injuries after falls. This deficient practice placed R19 at risk for further falls or injury.

Findings included:

- R19's Electronic Medical Record (EMR) documented diagnoses of severe dementia (group of thinking and social symptoms that interferes with daily functioning), unsteadiness on feet, muscle weakness, and chronic pain.

The "Significant Change Minimum Data Set" (MDS), dated 01/07/23, documented a Brief Interview for Mental Status (BIMS) score of zero, and short- and long-term memory problems with severely impaired decision making. The MDS documented R19 required extensive assistance of one staff for eating, hygiene, extensive assistance of two staff for bed mobility, transfers, walking, locomotion, toileting, dressing and total assistance with bathing. The MDS documented R19 had impaired balance and unable to

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stabilized without help, no range of motion impairment, and used a wheelchair.

The "Fall Care Area Assessment" (CAA), dated 01/20/23, documented R19 was at risk for falls secondary to balance and gait issues with transitions and ambulation.

The "Fall Care Plan," dated 01/17/23, documented R19 was at risk for falls secondary to balance, gait issues, ambulation, frequent falls, severe dementia, poor safety awareness, communication deficit, and potential medication side effects. The care plan directed staff to ensure R19 wore proper footwear prior to assisting her with transfers. The 03/20/2022 care plan update stated R19 was sent to the emergency room and received one staple to the back of her head. No further direction for staff for prevention of falls. The 06/19/2022 care plan update stated R19 was transported to the emergency room and returned with a new order for pain medication. No further direction for staff for prevention of falls. The 09/25/22 care plan update directed staff to perform frequent checks when R19 was in bed. The 01/02/23 care plan update directed staff to place of fall mat and Physical Therapy (PT) to evaluate R19 for a wheelchair positioning cushion. The 01/06/23 care plan update directed staff to assist R19 with ambulating before dinner using gait belt and wheelchair to follow as she attempts to ambulate without assistance before dinner. The 01/22/23 care plan update stated medication review. The 01/30/23 care plan update stated R19 was downgraded to a total lift with assistance of two staff for transfers when she was stiff or rigid.

The "Fall Risk Assessments" for the past year,

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dated 09/02/22 (16), 09/25/22 (15), and 01/6/23 (20) all indicated R19 was at high risk for falls (10 or higher indicated high fall risk).

The "Progress Note," dated 03/20/22 at 0751 AM, documented staff found R19 on the floor in her bathroom, seated upright with her feet and legs positioned in front of her, wearing tennis shoes. There was a splatter of blood on the bathroom floor behind her and a scant amount of blood was visible on the back of the resident's head. The physician order staff to send to R19 to the hospital.

The "Progress Note," dated 06/19/22 at 07:40 PM, documented R19 fell and hit her head, but did not lose consciousness per staff report. The note stated R19 had a medium sized hematoma (bruise with swelling) on the back of her head with a 3-centimeter (cm) purple/black line imprinted in it. Swelling and redness was also noted to outer area of purple line from hitting the door frame. R19 sent to the hospital via emergency services.

The "Progress Note," dated 06/20/2022 07:40 PM, stated the root cause of R19's fall was severe dementia; R19 walked around the neighborhood constantly, and lost her balance. The intervention would be a therapy screen.

The "Progress Note," dated 07/19/22 at 01:18 AM, documented staff found the resident lying down on the floor in the hallway, lying on her right side and asking for help. Later the resident complained of hip pain, and the nurse noted her right hip was swollen. X-rays revealed no acute injury. The root cause was dementia and R19 had difficulty making her needs known. The

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intervention was pain medication and staff obtained an order for X-ray of R19's right hip due to complaint of pain. The note stated the practitioner would review R19's medications.

The "Progress Note," dated 09/02/22 at 03:02 PM, R19 was found by staff in her own room but on the other side where she has a roommate, lying on her back. The fall was unwitnessed, neurological checks were started and were at baseline for the resident. The note recorded the immediate intervention was to assist the resident in taking a rest break after breakfast and lunch but this was not added to the care plan.

The "Progress Note," dated 09/25/22 at 03:35 PM, staff found R19 on the floor in her room, on her back right next to her bed and a pile of covers. Upon assessment the resident did not appear to be in any pain; her pupils were equal round reactive to light, hand grasps equal and strong She had no bruising to back or buttocks, and did not appear to have hit her head. Since the fall was not witnessed, staff proceeded with neurological checks as a precaution and they were at baseline. The note stated the nurse encouraged staff to perform frequent visual checks when R19 was resting in bed since she was prone to getting up an out of bed on her own. The note indicated the root cause was R19 was tangled in blankets and directed an immediate intervention to provide frequent checks when in bed though no time or frequency was specified.

The "Progress Note," dated 12/26/22 at 05:58 AM, documented staff found R19 on the floor in her room with her head resting on her bed rail with no visible injuries noted. The note documented staff notified her physician via fax

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and requested an order for non-skid socks while in bed due to the resident ambulated at will and had poor safety awareness due to dementia (after six falls). The note stated neurological assessments were initiated.

The "Progress Note," dated 1/2/23 at 05:30 PM, staff found R19 face down with arms and legs extended straight out. R19 wore shoes, call light was within reach, and her bed was in lowest position. No apparent injuries were noted, and neurological assessments were started. The note listed an immediate intervention for a fall mat, PT to evaluate R19 for a wheelchair positioning cushion.

The "Progress Note," dated 02/19/23 at 05:49 PM, documented R19 had a large bruise, approximately 14cm x 11.5cm to her right upper arm and a smaller bruise, approximately 9cm x 4cm, to the left of the larger bruise. The note stated both bruises were dark purple with light yellow at edges and had no swelling. R19 was guarding her right arm with tenderness. Her family was in house and notified of bruising. Per R19's representative's request, staff notified hospice and asked for an x-ray.

R19's medical record lacked neurological assessments after R19's 03/20/22 fall with head injury. The 06/19/22 fall with head injury neurological flowsheet was missing two scheduled neurological checks. The 09/25/22 unwitnessed fall neurological flowsheet had seven missing checks.

On 02/22/23 at 07:45 AM, observation revealed Certified Nurse Aide (CNA) O and Certified Medication Aide (CMA) S used the total lift to

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F 689	Continued From page 21 transfer R19 from her bed to her wheelchair. R19 spoke unintelligible words, but when asked if she had pain, R19 replied "No." Further observation revealed deep purple bruising to the upper back of R19's right arm, with yellowing bruising to the distal upper arm. When staff dressed R19, staff was gentle with R19's right arm, but she still clenched her teeth. When staff brought R19 out to the dining room, she had a sling on her right arm. On 02/27/23 at 08:50 AM, Administrative Nurse D verified staff had not completed neurological assessments after R19's unwitnessed fall and falls with head injury on 03/20/22, 06/19/22, and 09/25/22. She verified the care plan had not been updated after each fall with pertinent, effective and measurable fall prevention interventions. The facility's "Managing Falls and Fall Risk" policy, dated 2022, stated based on previous evaluations and current data staff would identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling or try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remained relevant. The facility failed to provide care and services to prevent further falls for R19, placing R19 at risk for further falls or injury.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		

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medication errors.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 89 residents. The sample included 18 residents with one reviewed for pain. Based on observation, interview, and record review the facility failed to prevent a medication error when pain medications were not administered as ordered by the physician for Resident (R) 19. This deficient practice place R19 at risk to potentially receive harmful amounts of her pain medication.

Findings included:

- R19's Electronic Medical Record (EMR) documented diagnoses of severe dementia (group of thinking and social symptoms that interferes with daily functioning) and chronic pain.

The "Significant Change Minimum Data Set" (MDS), dated 01/07/23, documented a Brief Interview for Mental Status (BIMS) score of zero, and short- and long-term memory problems with severely impaired decision making. The MDS documented R19 required extensive assistance of one staff for eating, hygiene, extensive assistance of two staff for bed mobility, transfers, walking, locomotion, toileting, dressing and total assistance with bathing. The MDS documented R19 had impaired balance and unable to stabilized without help, no range of motion impairment, and used a wheelchair.

R19's "Pain Care Plan," dated 01/17/23, directed staff to administer pain medication as ordered and staff to monitor pain as she was unable to voice the extent of her pain.

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The "Progress Note," dated 01/03/23 at 05:49 PM, documented R19 was admitted to hospice with the diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). New orders included oxycodone (narcotic pain medication used to treat severe pain), 5 milligrams (mg), take one tablet every four hours as needed for pain, resulting in six possible administrations.

The "Physician Order," dated 01/04/23, directed staff to administer oxycodone 5 mg four times per day at 08:00 AM, 12:00PM, 04:00PM and 08:00PM, for pain.

R19's "Medication Administration Record (MAR)," dated January 2023, documented staff administered oxycodone 5 mg every four hours from 01/04/23 to 01/09/23 unless the resident was sleeping or refused. R19 received oxycodone the following times:
01/04/23 at 08:00PM
01/05/23 at 12:00AM, 04:00AM, 08:00AM,12:00PM, 04:00 PM, and 08:00 PM.
01/06/23 at 12:00PM, 04:00PM and 08:00PM
01/07/23 at 08:00AM and 08:00PM.
01/08/23 at 04:00 AM, 08:00AM and 12:00PM
01/09/23 at 12:00AM, 04;00AM and 08:00AM

The "Progress Note," dated 01/05/23 at 03:36 PM, documented R19 continued taking scheduled oxycodone every four hours for pain, and upon assessment R19 was observed holding her head but she was sleeping. She has been resting in bed most of the shift.

The "Progress Note," dated 01/09/23 at 12:05 PM, documented staff spoke with R19's hospice nurse stating that family felt that R19 was being

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overmedicated. The note documented the facility reviewed the oxycodone prescription in the EMR and the medication frequency was put in incorrectly to be given every four hours instead of four times per day. The order was updated to match the original physician's order of oxycodone 5 milligrams (mg), four times per day.

On 02/22/23 at 07:45 AM, observation revealed Certified Nurse Aide (CNA) O and Certified Medication Aide (CMA) S used the total lift to transfer R19 from her bed to her wheelchair. R19 spoke unintelligible words, but when asked if she had pain, R19 replied "No." Further observation revealed deep purple bruising to the upper back of R19's right arm, with yellowing bruising to the distal upper arm. When staff dressed R19, staff was gentle with R19's right arm, but she still clenched her teeth. When staff brought R19 out to the dining room, she had a sling on her right arm.

On 02/27/23 at 08:50 AM, Administrative Nurse D stated providers entered their own medication orders in the facility's computer system which flagged a nurse to review. She said the facility did get some written or verbal orders. She verified staff had not correctly transcribed the physician orders for the pain medications and R19 had received more oxycodone than was prescribed.

The facility's "Administering Medications" policy, dated 2022, stated medications were administered in accordance with prescriber orders, including any required time frame.

The facility failed to ensure R19 was free from significant medication errors when staff administered an incorrect dose of pain

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F 760	Continued From page 25 medication placing R19 at risk to potentially receive harmful amounts of her pain medication.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 89 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to ensure the medication for Resident (R) 5 was labeled in accordance with currently accepted professional standards. This	F 761		

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deficient practice placed R5 at risk for medication errors.

Findings included:

- On 02/22/23 at 08:51 AM, observation revealed Certified Medication Aide (CMA) S applied a Salon Pas (pain medication) patch, 3.1/6%, to each of R5's knees.

The "Physician Order," dated 04/02/21, directed staff to apply the Salon Pas patch to R5's mid and lower back for pain daily.

On 02/22/23 at 01:06 PM, Licensed Nurse (LN) G verified the physician's order directed staff to administer R5's Salon Pas patches to his mid and lower back.

On 02/22/23 at 01:14 PM, CMA S showed R5's Salon Pas medication box had a handwritten message to apply to both legs. The pharmacy label was still on the box with the instruction to apply to mid and lower back.

On 02/22/23 at 01:15 PM, Administrative Nurse E verified the physician order directed staff to apply to mid and lower back and if the physician changed the order, staff were to have pharmacy change the label.

The facility's "Administering Medications" policy, dated 2022, stated medications were administered in accordance with prescriber orders. The policy stated the individual administering the medication checked the label to verify the right resident, right dosage, right time, and right method of administration.

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	175410	A. BUILDING _____ B. WING _____	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

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F 761	Continued From page 27 The facility failed to ensure the medication for R5 was labeled in accordance with currently accepted professional standards, placing R5 at risk to not receive his medication appropriately.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) 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 based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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F 880	Continued From page 28	F 880		

communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 89 residents. The sample included 18 residents with one reviewed for urinary catheter (tube inserted into the bladder to drain urine) or urinary tract infection (UTI). Based on observation, record review and

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F 880	Continued From page 29	F 880		

interview the facility staff failed to change gloves when providing Resident (R) 18 incontinent cares and continued to provide care with the same soiled gloves. This placed the resident at risk for infection.

Findings included:

- R18's Electronic Medical Record documented R18 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), dementia (progressive mental disorder characterized by failing memory, confusion), and muscle weakness.

R18's "Quarterly Minimum Data Set," dated 01/20/23, documented R18 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R18 required extensive staff assistance with transfers, locomotion off unit, bed mobility, toiler use and personal hygiene, limited staff assistance with locomotion on unit, and supervision with eating. The MDS documented R18 was frequently incontinent of bowel and urine.

R18's "Bowel and Bladder Care Plan," revised 01/24/23, documented R18 was frequently incontinent of bladder and bowel, wore incontinent products for skin protection and dignity. The care plan instructed staff to assess/record/report to the physician any signs or symptoms of UTI. The care plan documented R18 required extensive staff assistance by one staff member for her toileting needs, staff were to assist her upon rising for the day, before and after each meal/activity and approximately every two

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hours and as needed (PRN).

On 02/22/23 at 12:29 PM, observation revealed Certified Nurse Aide (CNA) Q propelled R18 in a wheelchair to her bathroom in her room, and applied a gait belt to R18. CNA Q then applied gloves, and placed 18's left hand on the grab bar on the wall while assisting R18 to stand and pivot back towards the toilet. CNA Q pulled down R18's pants and incontinent brief and assisted R18 in sitting on the toilet. R18 urinated, stated she was done, and CNA Q assisted R18 in standing, then provided perineal (genital area) care. Further observation revealed CNA Q, with the same soiled gloves, pulled up the resident's incontinent brief and pants, then touched R18's gait belt when assisting her in transferring to her wheelchair. With the same soiled gloves, CNA Q touched the handles of the wheelchair to propel R18 to the bathroom sink, then removed and discarded her gloves. CNA Q verified she had not changed her gloves and stated she had worked for the facility for five years and no one had shown her how to change gloves after providing perineal care, due to R18 was not stable when standing. CNA Q stated she would change gloves between dirty and clean when providing perineal care if R18 was in bed.

On 02/27/23 at 09:02 AM, Licensed Nurse (LN) H stated when she provided perineal care for R18, she would change gloves between dirty and clean.

The facility's "Perineal Care Policy," revised February 2018, instructed staff to place the equipment on the bedside stand, arrange the supplies so they could be easily reached, wash and dry hands or use hand sanitizer, put on

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F 880	Continued From page 31 gloves, wipe the resident's perineal area, from front to back, wipe the resident's rectal area thoroughly, then remove and discard gloves. The facility staff failed to change gloves when providing R18 incontinent cares and continued to provide care with the same soiled gloves. This placed the resident at risk for infection.	F 880		