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	175489	A. BUILDING _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 06/21/23.	F 000		
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 assessments. This REQUIREMENT is not met as evidenced by:	F 657		

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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The facility census totaled 31 residents with 12 included in the sample. Based on interview and record review, the facility failed to revise care plans for Resident (R) 28, related to falls.

Findings included:

- R28's electronic Medical Record (EMR) revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory and confusion), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Significant Change Minimum Data Set" (MDS) dated 11/20/22, revealed a "Brief Interview for Mental Status" (BIMS) score of eight, indicating moderate impairment in cognition. The resident required extensive assistance of two staff for daily cares and was frequently incontinent of bladder and bowel. The resident received pain medications on a scheduled and as needed basis.

The resident had a recent fall with a fracture. The Fall Risk Assessment dated 11/02/23 indicated the resident was high risk for falls.

Review of the "Quarterly MDS" dated 05/17/23, revealed a BIMS score of six, indicating severe cognitive impairment. The resident required assistance of one staff for supervision and physical assistance with transfers, ambulation,

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and toileting. The resident was a fall risk and had one non-injury and one minor injury fall since the last assessment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 11/20/22 revealed the resident could make herself understood, usually understood others but was unable to retain information, and staff were to anticipate her needs.

The "Falls CAA" dated 11/20/22 documented staff were to observe and assess for increased fall risks and eliminate them when able, and report concerns to the physician as needed/warranted. Staff were to observe and assess for interventions that decrease fall risks and implement as needed.

Review of the "Care Plan" dated 03/16/22, revealed the resident was a fall risk due to actual falls and deconditioning (weakness) and included the following interventions:

On 03/16/22, staff were to encourage the resident to participate in activities that would promote exercise and physical activity for strengthening and improved mobility.

On 03/16/22, staff were to ensure the resident wore appropriate footwear (non-skid socks or shoes) when ambulating or mobilizing in her wheelchair.

On 03/16/22, staff were to ensure the resident's walker was on the side of her bed, near the bathroom, at night to cue the resident to use the walker when she would get herself up to toilet.

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On 07/04/22, staff were to ensure the call light was within the residents reach and encourage her to use the call light for assistance.

On 06/13/23, staff placed anti-roll breaks on the resident's wheelchair.

On 09/19/23, staff were to provide visual checks during the night hours to ensure the resident's walker was in reach.

The care plan lacked revisions on the fall that occurred on 05/10/22, 11/14/22, 12/24/22, 02/03/23, and 05/20/23 to provide guidance to staff to possibly prevent the resident from further falls.

The "Fall Investigation" dated 05/10/22 at 07:40 AM revealed the resident reported she fell in her bathroom. She had diarrhea and weakness, and felt it was from Metformin (medication for control of the blood glucose). The medication was discontinued, and staff failed to review and revise the care plan for this fall.

The "Fall Investigation" dated 11/14/22 at 05:24 PM revealed the resident was found seated next to her recliner, leaned against the raised footrest. The call light had been clipped to the arm rest of her chair, her wheelchair was across the room, and the staff noted no injuries found and assisted the resident to the side of the bed. Staff failed to review and revise the care plan for this fall.

The "Fall Investigation" dated 12/24/22 at 02:45 PM revealed the resident was on the floor, sitting on her buttocks in front of her recliner. The resident reported she just slid out of her recliner. Staff failed to review and revise the care plan for

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this fall.

The "Fall Investigation" dated 02/03/23 at 06:54 AM revealed the resident was found sitting on the floor in her bathroom doorway facing her bed with her legs in front of her. The resident stated she had attempted to get back to her bed after using her bathroom. The resident sustained a small skin tear to her right ankle and her right elbow. Staff failed to review and revise the care plan for this fall.

The "Fall Investigation" dated 05/20/23 at 09:00 AM revealed a housekeeper reported the resident was on the floor. The resident observed against the bedframe at the head of the bed with her walker was up against the wall in the unlocked position. The bathroom had feces (bowel movement) on the floor. Two staff assisted the resident to her wheelchair. Staff observed the resident leaned backwards while in the standing position, and staff placed the resident in the wheelchair to take her to breakfast. The resident was unable to state how the fall occurred. The resident received a scrape to her left great toe as well as redness to her upper back. Staff failed to review and revise the care plan for this fall.

On 06/13/23 at 11:10 AM, Licensed Nurse (LN) J reported she did not add new interventions to the resident's care plan following her falls. LN J said she reviewed care plans before all care plan meetings and would update any problems/concerns then.

On 06/14/23 at 10:30 AM, Administrative Nurse B reported she expected staff to review the care plan and revise the care plan with falls, and if no revision was warranted, there should still be

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F 657	Continued From page 5 documentation. Review of the facility policy named "Care Plan Development and Revisions" dated 01/10/20 revealed revisions can be made any time changes are noted. These can be made by the Director of Nurses (DON), MDS coordinator, charge nurse, Dietary manager, or Social Services director. The facility failed to revise care plans for Resident (R) 28 related to falls.	F 657		
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 reported a census of 31 residents, with 12 sampled, including one resident sampled for activities of daily living (ADL). Based on observation, interview, and record review, the facility failed to provide care consistent with standard of practice for the one sampled Resident (R) 30 to maintain good grooming and personal hygiene related to showers, nail care, and facial hair removal. Findings included: - The 06/12/23 "Electronic Health Record" (EHR) documented R30 had the following diagnoses of presence of artificial hips right and left (surgery to replace hip joints with artificial parts) and emphysema (long-term, progressive disease of	F 677		

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the lungs characterized by shortness of breath).

The 05/27/23 "Significant Change Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of 14, indicating intact cognition. R30 required physical help of one staff for bathing/showering.

The 05/27/23 "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) documented R30 would require continued assistance from staff.

The 04/12/23 "Significant Change MDS" documented R30 required physical help in part of bathing/showering by one staff.

The 05/02/23 "Care Plan" documented staff were to check nail length, trim, and clean nails on bath days and as needed. R30 required one staff assistance with bathing.

The "Progress Notes" from March 2023 through June 2023, lacked documentation of the resident's refusals of showers/baths.

The "Tasks" in the EHR documented in the last 30 days, the resident received four (05/24/23, 05/31/23, 06/06/23, and 06/12/23) out of eight bathing opportunities.

On 06/12/23 at 10:45 AM, R30 observed sitting in his room in his recliner with long facial hair growth, greasy/oily appearing hair, and long jagged nails on both hands.

On 06/13/23 at 04:19 PM, R30 stated he does need assistance with showering and shaving, because he cannot see out of his right eye, and

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did not want to "cut up his face". R30 stated he had to ask when he wanted assistance with nail care or shaving and most of the time they would assist, he confirmed he did need them trimmed.

On 06/14/23 at 09:31 AM, R30 observed sitting in his room in his recliner with long jagged nails on both hands, R30 is clean shaven and had clean hair.

On 06/14/23 at 09:11 AM, certified nurse's aide (CNA) K, revealed she was the shower aide assigned to showers for the day. She stated if the residents refused, she would get the charge nurse. CNA K stated she offered nail care with each shower given. She stated showers were to be documented in the electronic record. CNA K stated she had not given R30 a shower recently.

On 06/14/23 at 09:39 AM, Licensed Nurse (LN) L revealed staff should document showers in the electronic record. LN L confirmed R30 required staff assistance with bathing.

On 06/14/23 at 01:26 PM, Administrative Nurse B revealed she expected her staff to provide bathing at least twice weekly, to document it in the electronic record, and to provide shaving and nail care with each encounter.

The facility 06/14/23 "Activity of Daily Living (ADL)" policy documented a resident who is unable to carry ADL will be receive the necessary services to maintain good nutrition, grooming, and oral and personal hygiene.

The facility failed to provide care consistent with professional standard of practice, for this resident that required assistance with bathing and facial

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F 677	Continued From page 8 hair removal, nail care, to maintain good grooming, and personal hygiene.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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 census totaled 31 residents with 12 residents in the sample, including two residents sampled for accident hazards. Based on observation, interview, and record review, the facility failed to provide timely and appropriate interventions to prevent further falls for Resident (R) 28. The resident had a history of multiple falls and fell while attempting to self-toilet and sustained a fractured humerus (bone of the upper arm). Findings included: - R28's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory and confusion), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and Alzheimer's disease (progressive mental	F 689		

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deterioration characterized by confusion and memory failure).

The "Significant Change Minimum Data Set" (MDS) dated 11/20/22, revealed a "Brief Interview for Mental Status" (BIMS) score of eight, indicating moderate impairment in cognition. The resident required extensive assistance of two staff for daily cares and was frequently incontinent of bladder and bowel. The resident received pain medications on a scheduled and as needed basis. The resident had a recent fall with a fracture. The Fall Risk Assessment dated 11/02/23 indicated the resident was high risk for falls.

Review of the "Quarterly MDS" dated 05/17/23, revealed a BIMS score of six, indicating severe cognitive impairment. The resident required assistance of one staff for supervision and physical assistance with transfers, ambulation, and toileting. The resident was a fall risk and had one non-injury and one minor injury fall since the last assessment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 11/20/22 revealed the resident could make herself understood, usually understood others but was unable to retain information, and staff were to anticipate her needs.

The "Falls CAA" dated 11/20/22 documented staff were to observe and assess for increased fall risks and eliminate them when able, and report concerns to the physician as needed/warranted. Staff were to observe and assess for interventions that decrease fall risks and implement as needed.

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Review of the "Care Plan" dated 03/16/22, revealed the resident was a fall risk due to actual falls and deconditioning (weakness) and included the following interventions:

On 03/16/22, staff to encourage the resident to participate in activities that promote exercise and physical activity for strengthening and improved mobility.

On 03/16/22, staff were to ensure the resident wore appropriate footwear (non-skid socks or shoes) when ambulating or mobilizing in her wheelchair.

On 03/16/22, staff were to ensure the resident's walker was on the side of her bed, near the bathroom, at night to cue the resident to use the walker when she would get herself up to toilet.

The "Care Plan" included the resident was incontinent of bladder (dated 07/04/22) and included the following interventions:

On 07/04/22, activity staff were to notify nursing staff if R28 was incontinent during activities.

On 07/04/22, staff were to establish voiding patterns for R28.

On 07/04/22, Certified Nurse Aide (CNA) to monitor/document for signs of urinary tract infection (UTI) such as pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.

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On 07/04/22, staff were to ensure the call light was within the residents reach and encourage her to use the call light for assistance.

On 06/13/23, anti-roll breaks were placed on the resident's wheelchair.

On 09/19/23, staff were to provide visual checks during the night hours to ensure the resident's walker was in reach.

The resident fell on 11/02/22 and staff placed a silent electronic motion alarm on the resident to alert staff when the resident attempted get up without staff knowledge as the resident would not call for assistance.

The care plan lacked fall prevention interventions after the falls that occurred on 05/10/22, 11/14/22, 12/24/22, 02/03/23, and 05/20/23.

The "Fall Investigation" dated 05/10/22 at 07:40 AM revealed the resident reported she fell in her bathroom. She had diarrhea and weakness, and felt it was from Metformin (medication for control of the blood glucose). The medication was discontinued, and staff failed to implement an intervention to keep the resident free from possible further falls.

The "Fall Investigation" dated 09/13/22 at 01:08 AM revealed the resident was found lying on the floor of her bathroom with her head between the toilet and the wall, and her legs extended straight out towards the door. R28 had one sock on, no undergarments, and had a shirt and a sweater in place. She hit her head and had visible bruising starting on her upper left back. Two staff got her

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up and walked her to bed. The staff noted she was wobbly and unsure what to do. Staff sat her on the side of the bed and R28 could not stay sitting up without holding onto the grab rail or the frame of the bed. She stated she got up to go to bathroom, and the next thing she knew, she was on the floor in the bathroom. The resident was incontinent, ambulated without proper footwear, and slipped and fell using her walker to ambulate herself to the toilet. A witness statement from CNA E documented she had not gone in to check the resident yet on her shift. (Her shift began at 10:00 PM and she had not checked on R28 three hours into her shift).

The "Fall Investigation" dated 11/02/22 at 08:10 AM revealed an unnamed Certified Medication Aide (CMA) heard the resident yelling for help and found the resident lying on the floor in her bathroom. The CMA notified the nurse, and the nurse found the resident lying on the floor with her head against the wall near the bathroom door. She was lying on her right side facing the doorway. The resident was alert and oriented to person only and could not tell the nurse what happened. The nurse observed bluish bruising with a small amount of swelling above R28's left eyebrow. The resident could not lift her left arm and cried out in pain when the nurse touched her arm. There was visible bruising on the resident's upper left arm near her shoulder. Three staff assisted the resident to her bed. At 08:30 AM (20 minutes after the fall), the staff notified the resident's Durable Power of Attorney (DPOA) of the fall and resident transfer to hospital for evaluation. At 08:32 AM, staff received an order to send the resident to emergency room (ER). At 08:50 AM, the resident left the facility in an ambulance (40 minutes after the resident's fall).

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Review of the investigation documented the resident had no injuries post fall, however, the update from the hospital revealed the resident had a fractured humerus. The care plan documented staff placed a silent electronic motion alarm on the resident to alert staff when the resident attempted mobility as the resident would not call for assistance.

The "Fall Investigation" dated 11/14/22 at 05:24 PM revealed the resident was found seated next to her recliner, leaned against the raised footrest. The call light had been clipped to the arm rest of her chair, her wheelchair was across the room, and the staff noted no injuries found and assisted the resident to the side of the bed. The investigation lacked an intervention to prevent further falls.

The "Fall Investigation" dated 12/24/22 at 02:45 PM revealed the resident was on the floor, sitting on her buttocks in front of her recliner. The resident reported she just slid out of her recliner. The investigation lacked an intervention to prevent further falls.

The "Fall Investigation" dated 02/03/23 at 06:54 AM revealed the resident was found sitting on the floor in her bathroom doorway facing her bed with her legs in front of her. Resident stated she had attempted to get back to her bed after using her bathroom. The resident sustained a small skin tear to her right ankle and her right elbow. The investigation lacked an intervention to prevent further falls.

The "Fall Investigation" dated 05/20/23 at 09:00 AM revealed a housekeeper reported the resident was on the floor. The resident was observed

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against the bedframe at the head of the bed with her walker was up against the wall in the unlocked position. The bathroom was observed to have feces (bowel movement) on the floor. Two staff assisted the resident to her wheelchair. Staff observed the resident leaned backwards while in the standing position, and staff placed the resident in the wheelchair to take her to breakfast. The resident was unable to state how the fall occurred. The resident received a scrape to her left great toe as well as redness to her upper back. The investigation lacked an intervention to prevent further falls and the care plan indicated the resident should have a silent alarm on.

The "Fall Investigation" dated 06/09/23 revealed the resident was found seated on the floor in front of her easy chair when her son came for a visit. The investigation lacked an intervention to prevent further falls. The care plan indicated staff should have had the silent electronic alarm on.

Review of a "Voiding Diary" dated 03/17/22, revealed it was not used due to inaccurate data. The staff did not do the voiding diary during the night or anytime the resident slept and only took the resident to the bathroom at approximately three-to-four-hour intervals instead of the required intervals on the voiding diary.

Review of the "Bowel and Bladder Assessment" completed on 02/15/23, revealed the resident was incontinent, needed assistance with toileting, was sometimes aware of need to void and a timed, scheduled toileting plan recommended. However, the facility lacked an individualized toileting plan.

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Review of the "Bowel and Bladder Assessment" completed on 05/17/23, revealed no changes from the previous assessment. Continued with no toileting plan.

Observation on 06/12/23 at 10:30 AM, revealed the resident slept while seated in her recliner. A wheelchair was approximately two feet in front of the resident and a wheeled walker parked against the wall by the door of the room approximately 20 feet away from the resident. A call light was clipped to the arm of the chair and no sensor monitor observed in the room.

Observation on 06/13/23 at 09:00 AM revealed CNA H assisted the resident from her recliner to her wheelchair. The resident wore skid free socks. CNA H lacked a gait belt and the staff failed to ask the resident if she needed to use the toilet. CNA H propelled the resident down the hall to the dining room and no motion sensor observed in the room.

Observation on 06/14/23 at 11:00 AM CNA I could not locate the electronic silent monitoring system at first, and then located the silent alarm, crawled under the resident's bed, and obtained the alarm system. CNA I confirmed the alarm was not used and was in the "off" position.

During an interview on 06/12/23 at 12:23 PM, a family member reported he came in last week and R28 was on the floor in her room. He thought maybe she was trying to get in her wheelchair from her recliner. He reported R28 could not remember to use the call light for assistance, and one of her falls resulted in a broken arm.

On 06/13/23 at 04:00 PM, CNA G reported the

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resident needed many reminders and was not that mobile since she broke her arm. CNA G stated R28 attempted to take herself to the bathroom has and had a lot of falls. CNA G did not know of the silent motion sensor in the resident's room and had not ever seen it.

On 06/14/23 at 09:40 AM CNA H reported she got the resident up for breakfast. The resident liked to sleep in, required extensive assistance of one staff, and walked in her room with her walker. CNA H stated R28 was not safe to ambulate by herself, and there was no toileting plan for the resident, and she was more incontinent. CNA H stated they put antiroll locks on her chair and CNA H did not know the resident had a silent alarm.

On 06/14/23 at 10:00 AM, CNA I reported the resident was very inconsistent and required assistance with her activities of daily living (ADL). She reported the resident did not have a toileting plan but thought that would be good for her. She did not know if the resident had a silent alarm and if she did, the staff were not using it.

On 06/13/23 at 11:10 AM, Licensed Nurse (LN) J reported she did not add new interventions to the resident's care plan following her falls. LN J said she reviewed care plans before all care plan meetings and would update any problems/concerns then.

On 06/14/23 at 10:30 AM, Administrative Nurse B stated after reviewing the resident fall history she felt a toileting plan would have benefitted the resident to prevent some of her falls. She also reported she expected staff to review the care plan and revised with falls, and if no revision was

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F 689	Continued From page 17 warranted there should still be documentation. The facility's policy for "Fall Protocol," dated 12/31/21, revealed the charge nurse would assess severity of fall/injury for need of emergency care, complete risk management assessment in the EMR including fall risk assessment, and the charge nurse would update interventions on the fall care plan with any new occurrence of falls. The facility failed to identify causal factors for the resident's falls and failed to provide timely and appropriate interventions to prevent further falls. The resident had a history of multiple falls and fell while attempting to self-toilet and broke her arm.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		

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as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 91 residents. The sample included 12 residents, with one resident sampled for bowel/ bladder incontinence. Based on observation, interview, and record review, the facility failed to provide an individualized toileting plan for Resident (R) 28, to ensure the resident remained as continent as possible.

Findings included:

- R28's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory and confusion), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and Alzheimer's disease (progressive mental deterioration characterized by confusion and

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memory failure).

The "Significant Change Minimum Data Set" (MDS) dated 11/20/22, revealed a "Brief Interview for Mental Status" (BIMS) score of eight, indicating moderate impairment in cognition. The resident required extensive assistance of two staff for daily cares and was frequently incontinent of bladder and bowel. The resident received pain medications on a scheduled and as needed basis. The resident had a recent fall with a fracture. The Fall Risk Assessment dated 11/02/23 indicated the resident was high risk for falls.

Review of the "Quarterly MDS" dated 05/17/23, revealed a BIMS score of six, indicating severe cognitive impairment. The resident required assistance of one staff for supervision and physical assistance with transfers, ambulation, and toileting. The resident was a fall risk and had one non-injury and one minor injury fall since the last assessment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 11/20/22 revealed the resident could make herself understood, usually understood others but was unable to retain information, and staff were to anticipate her needs.

The "Urinary Incontinence and Indwelling catheter" CAA dated 11/20/22, revealed the resident required staff assistance to toilet and would require continued assistance. Staff were to observe/assess for changes in continence and report concerns to her physician as needed. Staff were to observe/assess for interventions that promote a decrease in incontinence and

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implement. Staff were to observe/assess for complications including urinary tract infection (UTI) and skin breakdown and report those concerns to the physician for further treatment.

The "Care Plan" revealed the resident was incontinent of bladder (dated 07/04/22) and included the following interventions:

On 07/04/22, activity staff were to notify nursing staff if R28 was incontinent during activities.

On 07/04/22, staff were to establish voiding patterns for R28.

On 07/04/2022, Certified Nurse Aides (CNA's) were to monitor/document for signs of UTI such as pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or changes in eating patterns.

On 07/04/22, staff were to ensure the call light was within the residents reach and encourage her to use the call light for assistance.

On 06/13/23, anti-roll breaks were placed on the resident's wheelchair.

On 09/19/23, staff were to provide visual checks during the night hours to ensure the resident's walker was in reach.

The "Fall Investigation" dated 05/10/22 at 07:40 AM revealed the resident reported she fell in her bathroom. She had diarrhea and weakness, and felt it was from Metformin (medication for control

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of the blood glucose). The medication was discontinued, and staff failed to implement an intervention to keep the resident free from possible further falls.

The "Fall Investigation" dated 09/13/22 at 01:08 AM revealed the resident was found lying on the floor of her bathroom with her head between the toilet and the wall and legs extended straight out towards the door. R28 had one sock on, no undergarments and had a shirt and a sweater in place. She hit her head and had visible bruising starting on her upper left back. No other injuries noted. The resident denied pain. Two staff got her up and walked her to bed. She was wobbly and unsure what to do. She was sat on the side of the bed and could not stay sitting up without holding onto the grab rail or the frame of the bed. She stated she got up to go to bathroom, and the next thing she knew, she was on the floor in the bathroom. Review of the incident reported the resident was incontinent and walking without proper footwear and slipped and fell using walker to ambulate to BR. A witness statement from (CNA) E stated she had not gone in to check the resident yet on her shift. Her shift began at 10:00 PM, three hours into her shift.

The "Fall Investigation" dated 11/02/22 at 08:10 AM revealed an unnamed Certified Medication Aide (CMA) heard the resident yelling for help and found the resident lying on the floor in her bathroom. The CMA notified the nurse, and the nurse found the resident lying on the floor with her head against the wall near the bathroom door. She was lying on her right side facing the doorway. The resident was alert and oriented to person only and could not tell the nurse what happened. The nurse observed bluish bruising

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with a small amount of swelling above R28's left eyebrow. The resident could not lift her left arm and cried out in pain when the nurse touched her arm. There was visible bruising on the resident's upper left arm near her shoulder. Three staff assisted the resident to her bed. At 08:30 AM (20 minutes after the fall), the staff notified the resident's Durable Power of Attorney (DPOA) of the fall and resident transfer to hospital for evaluation. At 08:32 AM, staff received an order to send the resident to emergency room (ER). At 08:50 AM, the resident left the facility in an ambulance (40 minutes after the resident's fall). Review of the investigation documented the resident had no injuries post fall, however, the update from the hospital revealed the resident had a fractured humerus.

The "Fall Investigation" dated 02/03/23 at 06:54 AM revealed the resident was found sitting on the floor in her bathroom doorway facing her bed with her legs in front of her. Resident stated she was attempting to get back to bed after using her bathroom.

The "Fall Investigation" dated 05/20/23 at 09:00 AM revealed a housekeeper reported the resident was on the floor. Upon arrival R28 was observed against the bedframe at the head of the bed. Her walker was up against the wall in the unlocked position. Feces (bowel movement) was on the bathroom floor.

Review of a "Voiding Diary" dated 03/17/22, revealed it was not used due to inaccurate data. The staff did not do the voiding diary during the night or anytime the resident slept and only took the resident to the bathroom at approximately three-to-four-hour intervals instead of the required

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intervals on the voiding diary.

Review of the "Bowel and Bladder Assessment" completed on 02/15/23, revealed the resident was incontinent, needed assistance with toileting, was sometimes aware of the need to void and a timed, scheduled toileting plan recommended. However, the facility lacked an individualized toileting plan for R28.

Review of the "Bowel and Bladder Assessment" completed on 05/17/23, revealed no changes from the previous assessment. Continued with no toileting plan.

Observation on 06/13/23 at 9:00 AM revealed CNA H assisted the resident with a transfer to her wheelchair from her recliner. CNA H failed to offer the resident a toileting opportunity. Staff propelled the resident to the dining room for a meal.

On 06/13/23 at 4:00 PM CNA G reported is not that mobile since she broke her arm but still attempted to take herself to the bathroom by herself. She has had a lot of falls.

On 06/14/23 at 09:40 AM CNA H reported the resident was not safe to ambulate by herself. There is no toileting plan for the resident, and she is more incontinent.

On 06/14/23 at 10:00 AM CNA/RA I reported the resident is very inconsistent and needs assistance with her activities of daily living (ADLs). She reported the resident did not have a toileting plan but thought that would be good for her.

On 06/14/23 at 10:30 AM, Administrative Nurse B

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F 690	Continued From page 24 stated after reviewing the resident fall history she felt a toileting plan would have benefitted the resident to prevent some of her falls. The undated facility policy called "Bladder Schedule Voiding Protocol" revealed a voiding schedule based on a three-day voiding pattern assessment, comprehensive assessments including causal factors of the resident's incontinence, and progress and consultant notes would be placed in the resident's care plan. The facility failed to provide an individualized toileting plan for Resident (R) 28, to ensure the resident remained as continent as possible.	F 690		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents, with 12 residents sampled. Based on observation, interview, and record review, the facility failed on six days to have Registered Nurse (RN) coverage	F 727		

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F 727	Continued From page 25 for at least eight continuous hours daily in the last two months. Findings included: - The facility provided "Census Report" dated 06/12/23 noted 31 residents resided in the facility. On 06/12/23 at 07:30 AM, observation revealed 31 residents resided in the facility. Review of the nursing schedules for May 01, 2023, through June 12, 2023, documented six days with no consecutive eight hours of RN coverage (05/06/23, 05/07/23, 05/20/23, 05/21/23, 06/03/23, and 06/04/23). On 06/14/23 at 04:30 PM, Administrative Nurse B verified the facility lacked continuous eight-hour RN coverage for the six dates. She confirmed the management RN team had been covering what they could. The facility's "Staffing" policy revised 06/06/17 documented the facility would follow the state guidelines for staffing to provide sufficient numbers of qualified personnel to ensure that residents received services and care in accordance with Kansas state regulations. The facility would provide one RN for at least eight consecutive hours a day, seven days a week. The facility failed to provide RN coverage at least eight consecutive hours daily for the 31 residents who resided in the facility, placing the residents at risk for unsupervised nursing care and services.	F 727		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 26 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. The facility had one main kitchen. The kitchen served food to one main dining area. Based on observation, interview, and record review, the facility failed to properly store food in the main kitchen refrigerators due to foods left uncovered, boxes placed directly on the floor in the freezer and dry storage area, and staff failed to discard expired foods in accordance with professional standards for food service safety, to prevent food borne illness to the residents. Findings included: - During the brief initial tour of the kitchen, on 06/12/23 at 07:40 AM, observation revealed the following concerns:	F 812		

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	175489	A. BUILDING _____ B. WING _____	06/14/2023

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F 812	Continued From page 27	F 812		

1. The walk-in refrigerator had one undated, large sheet pan of yellow cake. One undated, large tub of salad mixes with cheese, five 32 ounce (oz.) tubs of yogurt with a use by date of 04/16/23. There was one three-pound (lb.) tub of ricotta cheese with a use by date of 06/02/23, six four-ounce yogurt cups with a use by date of 06/06/23, and a one five lb. tub of cottage cheese with a use by date of 06/09/23. Furthermore, a rolling cart with 15 uncovered, undated, serving cups of chocolate pudding/pie and three plates of sliced pie.

2. The walk-in freezer had four boxes and seven tubs of various ice cream flavors stored directly on the floor.

3. The reach in refrigerator had an opened, not resealed, undated 32 oz. package of lunch meat, an opened, not resealed, undated 2.3 lb. bag of lettuce, and an undated package of 16 sliced cheese. Furthermore, a large pan of prepared mashed potatoes with a use by date of 06/09/23.

4. The kitchen had two refrigerators and two freezers with temperature logs that were missing several days of readings, to include no dates on 06/04/23 and 06/05/23, no PM dates for the month of May 2023, no AM dates on 05/1/23 through 05/08/23 as well as other dates.

5. The kitchen dry storage area had three boxes stored directly on the floor with five boxes on top of them blocking the entrance into the area.

6. The kitchen had four large storage bins, one with flour, one with sugar, one with powdered sugar, and one with brown sugar. The lids of all

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F 812	Continued From page 28 four storage bins had dried light and dark areas, and debris on them. On 06/12/23 at 08:00 AM, Dietary staff D stated the dietary staff were all supposed to know to rotate the stock and check expiration dates. Dietary staff D stated the truck had just delivered and that was why the boxes and tubs were on the floor in the freezer and in the dry storage area. On 06/12/23 at 08:08 AM, Dietary staff C confirmed staff should not store boxes directly on the floor, and that she knew the truck had just delivered. Dietary staff C confirmed staff should discard expired foods, and that it was all dietary staff's responsibility to check that everything should be covered and dated once opened. The facility's 11/2019 policy for "Food and Nutrition" documented all staff would store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility failed to store food in accordance with professional standards for food service safety. This failure placed the 31 residents, who resided at the facility, at risk for food borne illness.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		

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F 883	Continued From page 29	F 883		

potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative

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was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents with 12 residents included in the sample which included five residents selected for review of influenza, pneumococcal, and COVID vaccines. Based on interview and record review, the facility failed to ensure the resident/resident representative received information/education regarding the benefits, risks, or medical contraindications of pneumococcal for three Residents (R), including R26, R23 and R35.

Findings included:

- Review of the Electronic health record (EHR) for Resident (R) 26, lacked documentation of any pneumococcal vaccine or declination of the vaccine provided to the resident and/or their representative to demonstrate the benefits verses risk of receiving the vaccine. The record lacked documentation the resident had been offered or provided an opportunity to receive the vaccine.

Review of the EHR for R 23 lacked documentation of any pneumococcal vaccine or declination of the vaccine provided to the resident and/or their representative to demonstrate the benefits verses risk of receiving the vaccine. The record lacked documentation the resident had been offered or provided an opportunity to receive the vaccine.

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Review of the EHR for R 35 lacked documentation of any pneumococcal vaccine or declination of the vaccine provided to the resident and/or their representative to demonstrate the benefits verses risk of receiving the vaccine. The record lacked documentation the resident had been offered or provided an opportunity to receive the vaccine.

On 06/13/23 at 09:00 AM, administrative Nurse B reported the residents did not get the vaccine as she could find no record of them. She reported she was not aware the residents should be offered the vaccine when they admitted to the facility.

On 06/13/23 at 01:00 PM, administrative Nurse B reported she located a consent form for the pneumococcal but verified staff had not been offering the vaccination. and identified 14 residents lacked pneumococcal vaccinations

Review of the facility policy named "Flu and Pneumonia Immunization" dated 01/17 revealed before offering the pneumococcal immunization, each resident or the resident representative would receive education regarding the benefits and potential side effects of the immunization. Each resident would be offered a pneumococcal vaccine, unless the immunization is medically contraindicated, or the resident has already been immunized. The resident or the resident representative can refuse immunization and the residents medical record includes documentation that indicates, at a minimum, the following: The resident or resident representative provided education regarding the benefits and potential side effects of pneumococcal immunization; and

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F 883	Continued From page 32 the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contradictions or refusal. The facility failed to provide proof of vaccination or declination of vaccines for pneumococcal for these three residents reviewed.	F 883		