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	175561	A. BUILDING _____ B. WING _____	10/04/2023

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MOUNT ST MARY	3700 E LINCOLN ST WICHITA, KS 67218

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 10/09/23.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility reported a census of 23 residents with 14 selected for review. Based on interview and record review, the facility failed to accurately assess one Resident (R)21's use of antipsychotic (a class of medications used to treat psychotic disorders) medication for the "Minimum Data Set" (MDS), as required. Findings included: - Review of Resident (R)21's "Physician Order Sheet," dated 08/09/23 revealed diagnoses included vascular dementia (progressive mental disorder characterized by failing memory, confusion) with agitation, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Admission Minimum Data Set" (MDS), dated 05/02/23, assessed the resident without use of antipsychotic (class of medications used	F 641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/09/2023

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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to treat psychosis and other mental emotional conditions) medication during the seven days look back period. Furthermore, the MDS indicated the resident did not receive antipsychotic medications since admission or on the prior assessment.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 05/02/23, assessed the resident with a history of dementia, anxiety, agitation, combativeness related to a history of cerebral vascular accident (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The resident received Abilify (an antipsychotic medication) and mirtazapine (antidepressant medication) for depression.

The "Quarterly MDS," dated 07/20/23, assessed the resident without use of antipsychotic medication use during the seven days look back period. Furthermore, this MDS indicated the resident did not receive antipsychotic medications since admission or on the prior assessment.

The "Care Plan," reviewed 08/14/23, instructed staff to review medications and record possible causes of cognitive deficit. Staff instructed to arrange for a psychiatric consult and follow up as indicated. Staff to monitor for adverse drug reactions. The "Care Plan" lacked interventions for the use of Abilify.

A "Physician's Order," dated 04/25/23, instructed staff to administer Ability, 2 milligrams, daily, for delusional disorder.
Interview, on 10/04/23 at 10:00 AM, with Administrative Nurse D, confirmed the use of

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F 641	Continued From page 2 Abilify, an antipsychotic for this resident's delusions, due to dementia. The facility utilized the "Resident Assessment Manual" (RAI) for policy regarding assessment accuracy. The facility failed to accurately identify and assess this residents use of the antipsychotic medication as required.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 23 residents with 14 residents sampled. Based on observation, interview, and record review, the facility failed to complete a comprehensive care plan for three Residents (R)11, R 15 and R 10, regarding lack of foot pedals on their wheelchairs and R 15, R 4 and R 6, regarding the antipsychotic (used to treat psychosis--any major mental disorder characterized by a gross impairment in reality testing) medication.

Findings included:

- Review of Resident (R)11's electronic medical record (EMR) revealed diagnoses which included: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and weakness.

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The "Annual Minimum Data Set" (MDS), dated 07/03/23, documented the resident had a "Brief Interview for Mental Status" (BIMS) score of four, indicating severe cognitive impairment. She required limited assistance of one staff for locomotion on the unit with the use of a wheelchair.

The "Activity of Daily Living (ADL)/Rehabilitation Potential CAA", dated 07/03/23, documented the resident required limited to extensive assistance with ADL's due to weakness and cognitive decline.

The "Quarterly MDS," dated 04/05/23, documented the resident had a BIMS score of six, indicating severe cognitive impairment. She required extensive assistance of two for locomotion on the unit with the use of her wheelchair.

The care plan, revised 07/25/23, lacked staff instruction for the use of foot pedals on her wheelchair while staff propelled the resident.

Review of the resident's EMR from 09/05/23 through 10/02/23 revealed the resident required extensive to total assistance on the unit in her wheelchair.

On 10/03/23 at 09:57 AM, CNA N propelled the resident from the dining room table to her room. The resident wore shoes and her feet skimmed the floor during transport. Her wheelchair lacked foot pedals.

On 10/03/23 at 02:03 PM, Certified Nurse Aide (CNA) M propelled the resident from the

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commons area to her room. The resident wore shoes and feet skimmed the floor during transport. Her wheelchair lacked foot pedals.

On 10/03/23 at 10:20 AM, CNA R propelled the resident's wheelchair around while gathering staff for an activity. The resident wore shoes and her feet skimmed the floor during transport. Her wheelchair lacked foot pedals.

On 10/03/23 at 09:57 AM, CNA M stated the resident had foot pedals somewhere in her room, but staff did not use them because the resident was able to propel herself in her wheelchair at times.

On 10/03/23 at 02:19 PM, CNA MM stated staff did not use foot pedals on the resident's wheelchair because she would propel herself at times.

On 10/04/23 at 09:18 AM, Administrative Nurse D stated the resident should have foot pedals on her wheelchair while staff propel her. A resident's feet should not skim on the floor during transport. The care plan should include staff instruction regarding foot pedals on the resident's wheelchair.

The facility policy for "Comprehensive Care Plans", implemented 03/28/18, included: The facility will develop and implement a comprehensive care plan for each resident in order to meet the resident's nursing needs as identified in the resident's comprehensive assessment.

The facility failed to complete a comprehensive care plan for this dependent resident regarding

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foot pedals for her wheelchair.

- Review of Resident (R)15's electronic medical record (EMR) revealed diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion) and agitation (turmoil).

The "Annual Minimum Data Set" (MDS), dated 07/26/23, documented the resident had a "Brief Interview for Mental Status" (BIMS) score of three, indicating severe cognitive impairment. She required extensive assistance of two staff for locomotion on the unit with the use of her wheelchair. The resident received an antipsychotic (used to treat psychosis--any major mental disorder characterized by a gross impairment in reality testing) medication seven days of the seven- day assessment period.

The "Activity of Daily Living (ADL)/Rehabilitation Potential CAA", dated 07/26/23, documented the resident required full assistance with all ADL's.

The "Psychotropic Drug Use CAA", dated 07/26/23, documented the resident's medications were monitored by the pharmacist every month.

The "Quarterly MDS," dated 05/11/23, documented the resident had a BIMS score of four, indicating cognitive impairment. She received antipsychotic medication seven days of the seven- day assessment period.

The care plan, revised 07/31/23, lacked staff instruction for the use of foot pedals on her wheelchair while staff propelled the resident. In addition, the care plan lacked staff instruction on

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the use of antipsychotic medication.

Review of the resident's EMR, from 09/04/23 through 10/02/23, revealed she required extensive to total assistance of one staff for locomotion on the unit while in her wheelchair.

Review of the resident's EMR revealed the following physician's order:

Seroquel (an antipsychotic medication), 25 milligrams (mg), by mouth (po), twice daily (BID), for agitation, ordered 02/16/23.

Seroquel, 50 mg, po, in the evening, for behavior symptoms of dementia, ordered 12/05/22.

Review of the resident's "Medication Administration Record" (MAR), for September 2023 and October 2023, revealed the resident received the antipsychotic medication, as ordered.

On 10/02/23 at 12:36 PM, Certified Nurse Aide (CNA) Q propelled the resident to the dining room table in her wheelchair. The resident's feet skimmed the floor during transport. The wheelchair lacked foot pedals.

On 10/03/23 at 09:53 AM, CNA M propelled the resident from the dining room to the commons area in her wheelchair. The resident's feet skimmed the floor during transport. The wheelchair lacked foot pedals.

On 10/03/23 at 12:05 PM, Licensed Nurse (LN) G propelled the resident from her room to the commons area for an activity in her wheelchair. The resident's feet skimmed the floor during

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transport. The wheelchair lacked foot pedals.

On 10/04/23 at 09:18 AM, Administrative Nurse D stated the resident should have foot pedals on her wheelchair while staff propel her. A resident's feet should not skim on the floor during transport. The care plan should include staff instruction regarding foot pedals on the resident's wheelchair. Administrative Nurse D stated the antipsychotic Seroquel should be included on the resident's care plan.

The facility policy for "Comprehensive Care Plans", implemented 03/28/18, included: The facility will develop and implement a comprehensive care plan for each resident in order to meet the resident's nursing needs as identified in the resident's comprehensive assessment.

The facility failed to complete a comprehensive care plan for this dependent resident regarding foot pedals for her wheelchair. In addition, the facility failed to develop and implement a comprehensive care plan for the use of an antipsychotic medication for this resident.

- Review of Resident (R)4's "Physician Order Sheet," dated 09/07/23, revealed diagnoses included dementia (progressive mental disorder characterized by failing memory and confusion), and visual hallucinations (sensing things while awake that appear to be real, but the mind created).

The "Admission Minimum Data Set" (MDS), dated 07/30/23, assessed the resident received seven days of antipsychotic (a class of

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medications used to treat severe mental disorders) medication during the seven days look back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 07/30/23, assessed the resident had a history of depression (feelings of sadness, worthlessness, and emptiness), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and hallucinations.

The "Care Plan," reviewed instructed staff to review medications and record possible causes of cognitive deficit. Staff were to provide medications that alleviate agitations as ordered by the physician and document side effects and effectiveness. The "Care Plan" lacked interventions for the use of Seroquel, a specific antipsychotic medication.

On 07/20/23, the physician instructed staff to administer Seroquel (antipsychotic medication), 25 milligrams (mg), every hour of sleep, for dementia.

On 09/20/23, the physician changed the diagnoses for administration from dementia to "Behavioral Psychological Symptoms of Dementia" (BPSD).

Observation, on 10/02/23 at 11:10 AM, revealed the resident seated in a chair in her room. The resident was friendly and responded to simple questions.

Interview, on 10/03/23 at 08:36 AM, with Certified Nurse Aide (CNA) M, revealed the resident was independent with cares, but did have episodes of

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feeling scared, paranoid (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), and hallucinated that evoked extreme fear.

Interview, on 10/04/23 at 10:30 AM, with Administrative Nurse D, confirmed the lack of use of antipsychotic medication (Seroquel) on the "Care Plan" for this resident.

The facility policy for "Comprehensive Care Plans", implemented 03/28/18, included: The facility will develop and implement a comprehensive care plan for each resident to meet the resident's nursing needs as identified in the resident's comprehensive assessment.

The facility failed to include the use of the antipsychotic medication Seroquel in this resident's care plan.

- Review of Resident (R) 6's "Physician Order Sheet," dated 06/17/23, revealed diagnosis of frontal temporal neurocognitive disorder (damage to nerve cells in the frontal and temporal lobes of the brain which result in behavior/personality changes), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major mood disorder.

The "Annual Minimum Data Set" (MDS), dated 09/04/23, staff assessment for cognitive skills for daily decision making as severely impaired with continuous inattention and disorganized thinking. The resident received seven days of antipsychotic, (a class of medications used to treat severe mental illness) antidepressant and antibiotic medications during the seven days look

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back period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 09/04/23, assessed the resident took Seroquel for agitation. Staff were to monitor mood and behavior daily.

The "Care Plan," reviewed 09/19/23, instructed staff the resident had severe dementia and needed step by step instructions, and would become agitated when she did not understand what was happening. Use of a weighted blanket may help to calm her down. The resident had poor impulse control. The care plan lacked indication that the resident received the antipsychotic medication Seroquel.

Observations, on 10/02/23 at 10:00 AM, revealed the resident seated in her wheelchair in the common living area, minimally participating in a balloon toss activity.

Observation, on 10/03/23 at 12:29 PM, revealed the resident in her bed. Interview, at that time with Certified Nurse Aide (CNA) M, revealed the resident could become agitated at times and staff had to reapproach the resident at a later time. The resident declined to get up out of bed for lunch, having slept through breakfast.

Interview, on 10/03/23 at 02:11 PM, with Licensed Nurse G revealed the resident would eventually get up out of bed with staff assistance, but staff needed to reapproach the resident several times.

Interview, on 10/04/23 at 10:30 AM, with Administrative Nurse D, confirmed the lack of use of antipsychotic medication (Seroquel) on the "Care Plan" for this resident.

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The facility policy for "Comprehensive Care Plans", implemented 03/28/18, included: The facility will develop and implement a comprehensive care plan for each resident to meet the resident's nursing needs as identified in the resident's comprehensive assessment.

The facility failed to include the use of the antipsychotic medication Seroquel in this resident's care plan.

- Review of Resident (R)10's "Physician Order Sheet," dated 09/19/23, revealed diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion) and polyosteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Annual Minimum Data Set" (MDS), dated 09/07/23, assessed the resident with a "Brief Interview for Mental Status" (BIMS) score of 03, which indicated severe cognitive impairment. The resident required extensive assistance for transfer and walking in the room but locomotion on the unit occurred once. The resident had impairment in functional range of motion on one side of her lower extremities.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 09/07/23, assessed the resident was on comfort care and her ADL ability changed due to recent respiratory infection and now required staff to propel her a wheelchair and from her room.

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The "Care Plan," reviewed 09/18/23, instructed staff the resident used a walker for short distances in her room with assistance but mostly used the wheelchair which she self-propelled or is pushed by staff. The care plan lacked instructions for use of foot pedals when staff propel the resident.

Observation, on 10/03/23 at 11:43 AM, revealed the resident seated in her wheelchair which lacked foot pedals. Certified Nurse Aide (CNA) N propelled the resident in her wheelchair from her room to the common living area, and both resident's feet skimmed along on the floor.

Observation, on 10/03/23 at 12:00 PM, revealed CNA M propelled the resident in her wheelchair to the dining room table. Both the resident's feet skimmed the floor.

Interview, on 10/03/23 at 01:49 PM, with Therapy Consultant GG, revealed the resident occasionally propelled herself in her wheelchair, and had leaning issues and weakness in her legs. Therapy Consultant GG stated foot pedals should be on a wheelchair when staff propelled a resident.

Interview, on 10/03/23 at 02:01 PM, with CNA N, revealed the resident should have foot pedals on her wheelchair when staff propel her but did not know if she had any foot pedals. CNA N stated sometimes the resident moved herself in the wheelchair but was now weaker and required staff assistance.

Interview, on 10/03/23 at 03:50 PM, with CNA N, revealed the resident did propel herself at times, but mostly staff propelled the resident when

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MOUNT ST MARY	3700 E LINCOLN ST WICHITA, KS 67218

(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 656	Continued From page 14 moving from the dining room to her room or common living area due to weakness. Interview, on 10/04/23 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to use foot pedals on a resident's wheelchair if they could not hold their feet up off the floor when propelling the resident. Administrative Nurse D confirmed the use of foot pedals when staff propel the resident was not on the care plan. The facility policy "Use of Assistive Devices", implemented 03/01/18, instructed staff to provide appropriate assistance to ensure the resident can use assistive devices such as wheelchair foot pedals appropriately and safely. Staff instructed to modify the relationship centered living plan of care as needed. The facility failed to develop a comprehensive care plan to ensure staff applied foot pedals to this dependent resident's wheelchair to safely propel this resident to prevent accidental injury when her feet skimmed the floor while staff propelled her wheelchair.	F 656		
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	F 657		

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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:
The facility reported a census of 23 residents with 14 residents sampled. Based on interview and record review, the facility failed to review and revise the care plan for one Resident (R)11, regarding new interventions following three non-injury falls.

Findings included:

- Review of Resident (R)11's electronic medical record (EMR) revealed diagnoses which included: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and weakness.

The "Annual Minimum Data Set" (MDS), dated 07/03/23, documented the resident had a "Brief Interview for Mental Status" (BIMS) score of four, indicating severe cognitive impairment. She

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required extensive assistance of two staff for toileting and had two or more non-injury falls since the prior assessment.

The "Falls CAA", dated 07/03/23, documented the resident had several falls the past two months due to poor safety awareness.

The "Quarterly MDS," dated 04/05/23, documented the resident had a BIMS score of six, indicating severe cognitive impairment. She required extensive assistance of two staff for toileting and had two or more non-injury falls since the prior assessment.

The care plan, revised 07/25/23, instructed the staff the resident was at high risk for falls due to balance problems and poor safety awareness. The resident had a motion detector in her room and staff were to toilet the resident before and after meals and activities, when she got up in the morning and before going to bed. Staff were also to keep the door to the resident's room open to keep an eye on her. The care plan lacked updates to include interventions for three non-injury falls that occurred on 07/01/23, 07/12/23, and 09/26/23.

Review of the resident's EMR revealed "Fall Risk Assessments" dated 09/26/23, 09/22/23, 09/16/23, 07/18/23, 07/12/23 and 07/01/23, which placed the resident at a high risk for falls.

Review of the resident's EMR revealed the resident had a non-injury fall on 07/01/23 at 11:14 AM, in her bathroom. Documentation lacked a fall intervention to prevent further falls.

Review of the resident's EMR revealed the

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F 657	Continued From page 17 resident had a non-injury fall on 07/12/23 at 10:20 PM, in her bathroom. Documentation lacked a fall intervention to prevent further falls. Review of the resident's EMR revealed the resident had a non-injury fall on 09/26/23 at 03:47 PM, in her bathroom. Documentation lacked a fall intervention to prevent further falls. On 10/03/23 at 09:57 AM, CNA M stated the resident's fall intervention was a motion detector on a shelf in her room. CNA M confirmed the resident would fall often. On 10/03/23 at 02:19 PM, CNA MM stated the resident had a motion detector in her room to keep her from falling. On 10/04/23 at 09:18 AM, Administrative Nurse D confirmed the facility failed to initiate new interventions for the falls on 07/01/23, 07/12/23 and 09/26/23 and stated the expectation was for staff to initiate a new intervention following each fall and include the new interventions on the resident's care plan. The facility policy for "Accidents and Supervision", implemented 04/27/22, included: The facility shall document all new interventions in the care plan for the individual resident and ensure the interventions are put into action. The facility failed to review and revise the care plan for this dependent resident following three non-injury falls in her bathroom.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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§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 23 residents with 14 selected for review which included three residents selected for Activities of Daily Living (ADL). Based on observation, interview, and record review, the facility failed to provide personal grooming to one Resident (R)14, of the three residents reviewed for ADL.

Findings included:

- Review of Resident (R)14's "Physician Order Sheet," dated 09/12/23, revealed diagnoses that included Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), cerebral vascular accident (CVA or stroke which is the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain, hemiplegia (paralysis of one side of the body), and hemiparesis (weakness on one side of the body).

The "Annual Minimum Data Set" (MDS), dated 09/05/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. The resident required extensive assistance for personal hygiene and had impairment in functional range of motion on one side of the upper and lower extremities.

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The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 09/05/23, assessed the resident as dependent in all daily tasks.

The "Care Plan," reviewed 09/18/23, instructed staff the resident's abilities for ADL fluctuate and staff were to monitor what assistance the resident would require as staff worked with him.

Observation, on 10/02/23 at 09:00 AM, revealed the resident seated in his wheelchair in the dining room. The resident had several days growth of facial hair.

Observation, on 10/03/23 at 08:28 AM, revealed the resident seated in his wheelchair in the common dining room. The resident continued to have several days growth of facial hair.

Observation, on 10/03/23 at 12:00 PM, revealed Certified Nurse Aide (CNA) M and CNA N, transferred the resident into bed. CNA M stated she thought the resident received a bath on Sundays by the second shift, but did not know what staff was responsible for shaving the resident. The resident stated the girl will shave him and attempted to touch his face.

Interview, on 10/03/23 at 12:15 PM, with Certified Nurse Aide (CMA) R, revealed she provided restorative care to the resident and shaving, but today was working as a medication aide as they had a staff member call off.

Interview, on 10/03/23 at 01:36 PM, with Licensed Nurse G, revealed staff should shave the resident with an electric razor. She stated the resident sometimes preferred certain staff to provide his

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F 677	Continued From page 20 cares, and two of those staff were off for the past three days. Interview on 10/03/23 at 02:35 PM, with CNA O, revealed he did get bed baths on the second shift most of the time, but usually his spouse shaved the resident. Interview on 10/04/23 at 10:00 AM, with Administrative Nurse G, revealed she would expect staff to provide grooming opportunities to the resident. The facility policy "Activities of Daily Living," implemented 03/01/18, instructed staff to provide the necessary services to maintain continence, good nutrition, grooming and personal and oral hygiene. The facility failed to ensure staff provided shaving opportunities to this dependent resident to enhance his sense of wellbeing.	F 677		
F 689 SS=D	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 reported a census of 23 residents with 14 residents sampled including three residents sampled for accidents. Based on	F 689		

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observation, interview, and record review, the facility failed to provide safe transport for two Residents (R)11 and R 10 and R 15, regarding lack of foot pedals on the resident's wheelchairs and failed to implement interventions following three non-injury falls for one R15.

Findings included:

- Review of Resident (R)11's electronic medical record (EMR) revealed diagnoses which included: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and weakness.

The "Annual Minimum Data Set" (MDS), dated 07/03/23, documented the resident had a "Brief Interview for Mental Status" (BIMS) score of four, indicating severe cognitive impairment. She required extensive assistance of two staff for toileting and limited assistance of one staff for locomotion on the unit with the use of a wheelchair. She was always incontinent of bladder and frequently incontinent of bowel. She had two or more non-injury falls since the prior assessment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 07/03/23, documented the resident had a history of dementia with short and long-term memory loss.

The "Falls CAA", dated 07/03/23, documented the resident had several falls the past two months due to poor safety awareness.

The "Activity of Daily Living (ADL)/Rehabilitation Potential CAA", dated 07/03/23, documented the resident required limited to extensive assistance

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with ADL's due to weakness and cognitive decline.

The "Quarterly MDS," dated 04/05/23, documented the resident had a BIMS score of six, indicating severe cognitive impairment. She required extensive assistance of two for toileting and required a wheelchair for locomotion on the unit. She was frequently incontinent of bowel and bladder. She had two or more non-injury falls since the prior assessment.

The care plan, revised 07/25/23, instructed staff the resident required staff assistance for propelling her wheelchair on the unit. The resident was at high risk for falls due to balance problems and poor safety awareness. The resident had a motion detector in her room and staff were to toilet the resident before and after meals and activities, when she got up in the morning and before going to bed. Staff were also to keep the door to the resident's room open to keep an eye on her.

Review of the resident's EMR revealed "Fall Risk Assessments" dated 09/26/23, 09/22/23, 09/16/23, 07/18/23, 07/12/23 and 07/01/23, which placed the resident at a high risk for falls.

Review of the resident's EMR revealed the resident had a non-injury fall on 07/01/23 at 11:14 AM, in her bathroom. Documentation lacked a fall intervention to prevent further falls.

Review of the resident's EMR revealed the resident had a non-injury fall on 07/12/23 at 10:20 PM, in her bathroom. Documentation lacked a fall intervention to prevent further falls.

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Review of the resident's EMR revealed the resident had a non-injury fall on 09/26/23 at 03:47 PM, in her bathroom. Documentation lacked a fall intervention to prevent further falls.

Review of the resident's EMR from 09/05/23 through 10/02/23 revealed the resident required extensive to total assistance on the unit in her wheelchair.

On 10/03/23 at 09:57 AM, CNA N propelled the resident from the dining room table to her room. The resident wore shoes and her feet skimmed the floor during transport. Her wheelchair lacked foot pedals.

On 10/03/23 at 02:03 PM, Certified Nurse Aide (CNA) M propelled the resident from the commons area to her room. The resident wore shoes and feet skimmed the floor during transport. Her wheelchair lacked foot pedals.

On 10/03/23 at 10:20 AM, CNA R propelled the resident's wheelchair around while gathering staff for an activity. The resident wore shoes and her feet skimmed the floor during transport. Her wheelchair lacked foot pedals.

On 10/03/23 at 09:57 AM, CNA M stated the resident had foot pedals somewhere in her room, but staff did not use them because the resident was able to propel herself in her wheelchair at times. CNA M stated the resident's fall intervention was a motion detector on a shelf in her room. CNA M confirmed the resident would fall often.

On 10/03/23 at 02:19 PM, CNA MM stated staff did not use foot pedals on the resident's

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wheelchair because she would propel herself at times. The resident has a motion detector in her room to keep her from falling.

On 10/04/23 at 09:18 AM, Administrative Nurse D stated the resident should have foot pedals on her wheelchair while staff propel her. A resident's feet should not skim on the floor during transport. Administrative Nurse D confirmed the facility failed to initiate new interventions for the falls on 07/01/23, 07/12/23 and 09/26/23 and stated the expectation was for staff to initiate a new intervention following each fall.

The facility policy for "Use of Assistive Devices", implemented 03/01/18, included: The facility staff will provide appropriate assistance to ensure the residents can use assistive devices, such as wheelchair foot pedals, appropriately and safely.

The facility policy for "Accidents and Supervision", implemented 04/27/22, included: The facility will establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents, including falls. The facility shall document the new interventions in the care plan for the individual resident and ensure the interventions are put into action.

The facility failed to provide safe staff transports for this dependent resident while in her wheelchair and failed to implement new interventions following three non-injury falls.

- Review of Resident (R)15's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by

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failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 07/26/23, documented the resident had a "Brief Interview for Mental Status" (BIMS) score of three, indicating severe cognitive impairment. She required extensive assistance of two staff for locomotion on the unit with the use of her wheelchair.

The "Activity of Daily Living (ADL)/Rehabilitation Potential CAA", dated 07/26/23, documented the resident required full assistance with all ADL's.

The "Quarterly MDS," dated 05/11/23, documented the resident had a BIMS score of four, indicating cognitive impairment. She required extensive assistance of two staff for locomotion on the unit with e use of her wheelchair.

The care plan, revised 07/31/23, instructed staff the resident required extensive assistance of two staff for location on the unit with her wheelchair.

Review of the resident's EMR, from 09/04/23 through 10/02/23, revealed she required extensive to total assistance of one staff for locomotion on the unit while in her wheelchair.

On 10/02/23 at 12:36 PM, Certified Nurse Aide (CNA) Q propelled the resident to the dining room table in her wheelchair. The resident's feet skimmed the floor during transport. The wheelchair lacked foot pedals.

On 10/03/23 at 09:53 AM, CNA M propelled the resident from the dining room to the commons area in her wheelchair. The resident's feet

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skimmed the floor during transport. The wheelchair lacked foot pedals.

On 10/03/23 at 12:05 PM, Licensed Nurse (LN) G propelled the resident from her room to the commons area for an activity in her wheelchair. The resident's feet skimmed the floor during transport. The wheelchair lacked foot pedals.

On 10/03/23 at 09:53 AM, CNA M stated the resident did not have foot pedals for her wheelchair. The resident would propel herself at times.

On 10/03/23 at 12:05 PM, LN G stated the resident did not have foot pedals for her wheelchair because she would at times propel herself.

On 10/04/23 at 09:18 AM, Administrative Nurse D stated the resident should have foot pedals on her wheelchair while staff propel her. A resident's feet should not skim on the floor during transport.

The facility policy for "Use of Assistive Devices", implemented 03/01/18, included: The facility staff will provide appropriate assistance to ensure the residents can use assistive devices, such as wheelchair foot pedals, appropriately and safely.

The facility failed to provide safe staff transports for this dependent resident while in her wheelchair.

- Review of Resident (R)10's "Physician Order Sheet," dated 09/19/23, revealed diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion) and

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polyosteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Annual Minimum Data Set" (MDS), dated 09/07/23, assessed the resident with a "Brief Interview for Mental Status" (BIMS) score of 03, which indicated severe cognitive impairment. The resident required extensive assistance for transfer and walking in the room but locomotion on the unit occurred once. The resident had impairment in functional range of motion on one side of her lower extremities.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 09/07/23, assessed the resident was on comfort care and her ADL ability changed due to recent respiratory infection and now required staff to propel her a wheelchair and from her room.

The "Care Plan," reviewed 09/18/23, instructed staff the resident used a walker for short distances in her room with assistance but mostly used the wheelchair which she self-propelled or is pushed by staff. The care plan lacked instructions for use of foot pedals when staff propel the resident.

Observation, on 10/03/23 at 11:43 AM, revealed the resident seated in her wheelchair which lacked foot pedals. Certified Nurse Aide (CNA) N propelled the resident in her wheelchair from her room to the common living area, and both of the resident's feet skimmed along on the floor.

Observation, on 10/03/23 at 12:00 PM, revealed CNA M propelled the resident in her wheelchair to

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MOUNT ST MARY	3700 E LINCOLN ST WICHITA, KS 67218

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the dining room table. Both the resident's feet skimmed the floor.

Interview, on 10/03/23 at 01:49 PM, with Therapy Consultant GG, revealed the resident occasionally propelled herself in her wheelchair, and had leaning issues and weakness in her legs. Therapy Consultant GG stated foot pedals should be on a wheelchair when staff propelled a resident.

Interview, on 10/03/23 at 02:01 PM, with CNA N, revealed the resident should have foot pedals on her wheelchair when staff propel her but did not know if she had any foot pedals. CNA N stated sometimes the resident moved herself in the wheelchair but was now weaker and required staff assistance.

Interview, on 10/03/23 at 03:50 PM, with CNA N, revealed the resident did propel herself at times, but mostly staff propelled the resident when moving from the dining room to her room or common living area due to weakness.

Interview, with Administrative Nurse D, revealed she would expect staff to use foot pedals on a resident's wheelchair if they could not hold their feet up off the floor when propelling the resident.

The facility policy "Use of Assistive Devices", implemented 03/01/18, instructed staff to provide appropriate assistance to ensure the resident can use assistive devices such as wheelchair foot pedals appropriately and safely.

The facility failed to ensure staff applied foot pedals to this dependent resident's wheelchair to safely propel this resident to prevent accidental

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F 689	Continued From page 29 injury when her feet skimmed the floor while staff propelled her wheelchair.	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 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	F 690		

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possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 23 residents with 14 selected for review which included two residents reviewed for urinary incontinence. Based on observation, interview, and record review, the facility failed to ensure voiding assessment and timely incontinence care for one Resident (R)14, of the two residents reviewed for urinary incontinence.

Findings included:

- Review of Resident (R)14's "Physician Order Sheet," dated 09/12/23, revealed diagnoses that included Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), cerebral vascular accident (CVA or stroke which is the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain, hemiplegia (paralysis of one side of the body), and hemiparesis (weakness on one side of the body).

The "Annual Minimum Data Set" (MDS), dated 09/05/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. The resident required extensive assistance for personal hygiene, was dependent on staff for toileting and had impairment in functional range of motion on one side of the upper and lower extremities. The resident was always incontinent of bowel and bladder.

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The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 09/05/23, assessed the resident as dependent in toileting and was on a check and change program for incontinence.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" CAA, dated 09/05/23, assessed the resident wore briefs for protection and required total assistance with changing and staff anticipate his needs.

The "Care Plan," reviewed 09/18/23, instructed staff to monitor/document bladder and bowel function and if incontinent, monitor for appropriate bowel and bladder training program and implement. Staff instructed to keep skin clean and dry, and the resident was on a check and change toileting schedule.

Observation, on 10/03/23 at 07:28 AM, revealed the resident seated in his wheelchair in the common dining room.

On 10/03/23 at 09:31 AM, the resident's family member completed feeding the resident breakfast.

On 10/03/23 at 10:07 AM, Certified Nurse Aide (CNA) N, propelled the resident to the common living area.

Observations continued 10/03/23 at 15-minute intervals and revealed staff failed to check/change the resident until 12:00 PM, (four hours and 28 minutes) at which time CNA N propelled the resident to the dining room table for lunch, at which time a skin check requested.

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Observation, on 10/03/23 at 12:00 PM, revealed Certified Nurse Aide (CNA) M and CNA N, transferred the resident into bed with the mechanical lift. CNA M confirmed staff did not provide a check and change opportunity for the resident until this time. The resident was incontinent of stool and as staff removed the resident's incontinent brief, the resident stated that he needed to urinate and proceeded to urinate in his brief.

Interview, on 10/03/23 at 01:36 PM, with Licensed Nurse (LN) G, revealed staff should check and change the resident before and after meals, and every two hours during the night. LN G stated the resident does use his call light when in bed, and often notified staff that he was wet.

Interview on 10/03/23 at 02:35 PM, with CNA O, revealed the resident was on a check and change program for incontinence and the resident did use his call light when in bed but he usually was incontinent of bowel and bladder.

Interview on 10/04/23 at 10:00 AM, with Administrative Nurse G, revealed she would expect staff to provide check and change for urinary incontinence before and after meals and throughout the night. Administrative Nurse G stated the facility did not complete a voiding diary for the resident or assess for a pattern.

The facility policy "Incontinence," implemented 11/2022, instructed staff that incontinent resident receive appropriate treatment to prevent infections and to restore continence to the extent possible.

The facility policy "Activities of Daily Living,"

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F 690	Continued From page 33 implemented 03/01/18, instructed staff to provide the necessary services to maintain continence, good nutrition, grooming and personal and oral hygiene. The facility failed to ensure staff provided incontinence care in a timely manner (four hours and 28 minutes) and to assess for strategies to promote continence for this resident who identified the need to urinate.	F 690		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 23 residents. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for one of five Certified Nurse Aides (CNA) reviewed, CNA P, to ensure adequate appropriate cares and services provided to the residents of the facility. Findings included: - Review of five Certified Nurse Aides (CNA), employed by the facility for greater than one year, revealed the following concern: CNA P, hired 08/01/22, lacked an annual performance review in her personnel file.	F 730		

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F 730	Continued From page 34 On 10/03/23 at 03:23 PM, Administrative Nurse D stated not all the staff annual evaluations had been completed. The facility policy for "Guidelines for Completion of Annual Evaluation Forms", effective 03/01/22, included: Supervisors will complete an annual evaluation for each employee annually to include a plan for professional or personal work-related goals. The facility failed to complete an annual performance review at least once every 12 months for this CNA, hired 08/01/22, to ensure adequate appropriate cares and services provided to the residents of the facility.	F 730		
F 880 SS=F	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	F 880		

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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 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.

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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 reported a census of 23 residents. Based on interview and record review, the facility failed to ensure ongoing infection surveillance to determine risks of infections to the residents of the facility.

Findings included:

- Review of the "Infection Control Monthly Logbook," revealed lack of September 2023 log for infections.

Interview on 10/04/23 at 08:30 AM, with Administrative Nurse D, revealed the September 2023 log was not completed as staff compiled the logs at the end of the month, not on an ongoing basis to track and trend infections in real time. Administrative Nurse D stated staff discuss infections in "Risk Meetings", but actual tracking and trending of infections was done at the end of the month.

The facility policy "Infection Surveillance Overview," undated, instructed staff that infection prevention begins with ongoing surveillance to identify infections that are causing or have potential to cause an outbreak in the facility. Surveillance is crucial in the identification of possible clusters, changes in prevalent organisms or increases in the rate of infections

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F 880	Continued From page 37 promptly. The facility failed to provide infection tracking and trending in an ongoing basis as required to prevent the spread of infection amongst the residents.	F 880		