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	175445	A. BUILDING _____ B. WING _____	10/17/2024

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PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(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 and complaint investigation KS00190881. The 2567 was sent electronically on 10/24/24.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents. One resident was sampled for reasonable accommodations of resident needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R)45 had a call light within her reach. This deficient practice left R45 vulnerable to unmet care needs due to the inability to call for staff assistance. Findings included: - R45's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of aphasia (condition with disordered or absent language function) following cerebral infarction (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), hemiparesis/hemiplegia (weakness and	F 558		

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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paralysis on one side of the body) affecting left dominant side, dysphagia (swallowing difficulty), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hypertension (HTN-elevated blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Significant Change Minimum Data Set" (MDS) dated 09/02/24 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R45 was dependent on staff for toileting, bathing, and dressing, and was independent with eating.

R45's "Activity of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 09/02/24 documented R45 could feed herself after staff set-up, R45 was dependent on staff for all other activities of daily living (ADLs). She required a mechanical lift and used a Broda chair (a specialized wheelchair with the ability to tilt and recline).

R45's "Care Plan" dated 06/13/24 documented R45 had left-sided paralysis and was a fall risk. Staff were to help R45 with bed positioning, and to propel her wheelchair. R45's plan of care did not include any direction regarding her call light placement.

On 10/14/24 at 08:35 AM, R45 sat in her room in

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her Broda chair. R45's call light was clipped to her blanket, and R45's blanket was down by her lower legs, feet, and the floor. R45's call light and blanket were out of R45's reach.

On 10/15/24 at 08:50 AM R45 sat in her Broda chair watching TV. R45's call light lay on her bed, out of her reach.

On 10/17/24 at 11:33 PM Licensed Nurse (LN) G stated call lights should be clipped to the resident or be within the resident's reach. LN G stated staff were trained to put the call light within the resident's reach even if the call light was not addressed in the plan of care.

On 10/17/24 at 11:47 PM, Certified Nurse's Aide (CNA) M stated call lights should always be within the resident's reach, and staff should let the resident know where the call light has been placed. CNA M stated residents need their call light to call for assistance.

On 10/17/24 at 01:01 PM Administrative Nurse D stated the resident's call light should be placed anywhere the resident can reach the light.

The facility's "Accommodation of Needs" policy documented the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and achieving safe independent functioning, dignity, and well-being. The resident's individual needs and preferences will be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical

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F 558	Continued From page 3 environment, shall be evaluated upon admission and reviewed on an ongoing basis. The facility failed to ensure R45's call light was within her reach. This deficient practice left R45 vulnerable to unmet care needs due to the inability to call for staff assistance.	F 558		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		

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(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

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(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The sample included 13 residents with two residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide written notice for a facility-initiated transfer as soon as practicable for Resident (R) 31. This deficient practice placed R31 at risk of uninformed choices and miscommunication regarding care needs.

Findings included:

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- R31's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary incontinence, overweight, neoplasm (tumor) of right breast, and back pain.

The "Annual Minimum Data Set" (MDS) dated 09/12/24 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented that R31 needed substantial to maximum assistance with transfers.

R31's "Falls Care Area Assessment" (CAA) dated 09/12/24 documented she had a recent fall that resulted in a laceration that required sutures.

R31's "Care Plan" dated 11/06/22 documented that staff would place a note to remind her to use her call light for all assistance.

R31's EMR under the "Progress Notes" tab revealed a "Social Services Note" on 09/16/24 at 08:11 AM that documented R31 was transferred to the hospital and admitted.

On 09/17/24 at 04:54 PM a "Social Services Progress Note" documented R31 was admitted from the hospital.

The facility was unable to provide evidence a written notice of transfer or discharge notification was provided to R31 or the legal representative when R31 transferred to the hospital on the above dates.

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F 623	Continued From page 7 On 10/15/24 at 07:26 AM R31 sat in her wheelchair. R31 waited to go to the dining room for breakfast. On 10/17/24 at 01:45 PM, Administrative Staff A verified he was unable to locate the written notification provided to the resident or his legal representative regarding R31's facility-initiated transfer to the hospital. The facility's "Discharge Criteria" policy dated 11/28/17 documented that residents are permitted to remain in the facility and not be transferred or discharged unless appropriate discharge criteria are met. The resident may be transferred or discharged if the resident's welfare and the resident's needs cannot be met in the facility. The facility would l provide a written notice of transfer or discharge to the resident or the resident's legal representative. The facility failed to provide written notice of transfer as soon as practicable for R31's facility-initiated transfers. This deficient practice placed R31 at risk of uninformed choices and miscommunication regarding care needs.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		

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any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The sample included 13 residents with two residents reviewed for hospitalization. Based on observations, record review, and interview the facility failed to provide a bed hold notice with the required information to Resident (R) 31 and/or their legal representative when R31 transferred to the hospital. This deficient practice placed R31 at risk for impaired ability to return to the facility or her same room.

Findings included:

- R31's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body

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cannot respond to the insulin), urinary incontinence, overweight, neoplasm (tumor) of right breast, and back pain.

The "Annual Minimum Data Set" (MDS) dated 09/12/24 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented that R31 needed substantial to maximum assistance with transfers.
R31's "Falls Care Area Assessment" (CAA) dated 09/12/24 documented she had a recent fall that resulted in a laceration that required sutures.

R31's "Care Plan" dated 11/06/22 documented that staff would place a note to remind her to use her call light for all assistance.

R31's EMR under the "Progress Notes" tab revealed a "Social Services Note" on 09/16/24 at 08:11 AM R31 was transferred to the hospital and admitted.

R31's EMR lacked evidence a bed hold policy was provided to R31 or their representative.

On 09/17/24 at 04:54 PM a "Social Services Progress Note" documented R31 was admitted from the hospital.

The facility was unable to provide, as requested, evidence a bed hold notice was provided to R31 when she was discharged from the hospital.

On 10/15/24 at 07:26 AM R31 sat in her wheelchair. R31 waited to go to the dining room for breakfast.

On 10/17/24 at 01:45 PM, Administrative Staff A

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F 625	Continued From page 10 verified he was unable to locate evidence a bed-hold notification was provided to the resident or his legal representative regarding R31's facility-initiated transfer to the hospital. The facility's "Bed-Hold Policy Notice" dated 11/28/17 documented a written notice that specifies the duration of the bed-hold policy would be provided at the time of transfer of a resident for hospitalization or therapeutic leave. The notice would specify the duration of the bed-hold policy. The facility failed to provide a bed hold notice to R31 and/or her representative when transferred to the hospital. This deficient practice placed R31 at risk for impaired ability to return to the facility or his same room.	F 625		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with three	F 686		

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residents reviewed for treatment and services to prevent and heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 45's offloading boots were applied to her heels to prevent pressure ulcers. The facility also failed to ensure that R29's pressure-relieving cushion was in his wheelchair. This placed R45 and R29 at increased risk for worsening pressure ulcers and the development of new pressure ulcers.

Findings Included:

- R45's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of aphasia (a condition with disordered or absent language function) following cerebral infarction (stroke - 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), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting left dominant side, dysphagia (swallowing difficulty), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hypertension (HTN-elevated blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

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The "Significant Change Minimum Data Set" (MDS) dated 09/02/24 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R45 was dependent on staff for toileting, bathing, dressing, and independent with eating. R45's MDS documented R45 was at risk for developing pressure ulcers.

R45's "Pressure Ulcer/ Injury Care Area Assessment " dated 09/02/24 documented R45 could feed herself after set-up but was dependent on all other activities of daily living (ADLs). She requires a mechanical lift and uses a Broda chair (a specialized wheelchair with the ability to tilt and recline). R45's CAA documented she was incontinent of bowel and bladder.

R45's "Care Plan" dated 06/23/24 documented that R45 needed nursing staff to do weekly skin checks. Staff were to keep a pressure always relieving cushion in R45's wheelchair. Staff were to monitor R45's skin every time she bathes. Staff were to place a pressure-relieving mattress on R45's bed.

R45's "Braden Scale for Prediction Pressure Sore Risk" dated 05/03/24 documented a score of 13 indicating a high risk for pressure ulcers.

R45's "Weekly Wound Assessment" dated 09/30/24 documented the right heel wound. The assessment was "in progress."

R45's physician's orders under the "Orders" tab revealed the following orders:
Skin-prep (liquid skin protectant) to left and right heels every evening dated 09/30/24.
Offloading boots on always, every shift for wound

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dated 10/14/24.

On 10/14/24 at 08:35 AM, R45 sat in her room, in her Broda chair. R45 had one boot on her right heel.

On 10/15/24 at 08:50 AM R45 sat in her Broda chair watching TV. R45 had one boot on her right heel. R45 stated the facility could not find her other boot, for her left foot. She stated staff put the one boot on, and she was still waiting for another boot.

On 10/17/24 at 11:33 AM Certified Nurse's Aide (CNA) M stated if a resident needed boots, staff would know by looking at the plan of care. CNA M stated if R45's boots were not in place, they might have been sent to the laundry.

On 10/17/24 at 11:47 AM Licensed Nurse (LN) G stated if a resident needed to wear boots, it would show on the "Treatment Administration Record" (TAR). She stated the nurse was responsible for any treatments on the TAR. LN G stated the nurse would ensure the pressure-relieving boots were placed on the residents' heels.

On 10/17/24 at 01:01 PM Administrative Nurse D stated if a resident needed pressure relieving boots, the boots should be available. She stated nursing could go to the therapy rooms to get extra boots for residents if the residents' boots were in the laundry or missing. Administrative D stated the nurses and CNAs would know that a resident required offloading boots by reviewing the resident's plan of care.

The facility's "Wound Assessment, Prevention, and Treatment" policy dated 11/28/17

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documented that a resident who enters the facility without pressure ulcers would not develop them unless the individual's clinical condition demonstrates that they were unavoidable. Residents would be evaluated and monitored to prevent the development of pressure ulcers and to promote rapid healing of any pressure ulcers that are present. A comprehensive, individualized care plan would be developed to address the prevention of pressure ulcers, management of risk factors, and treatment strategies for residents with pressure ulcers. The strategies would be developed through collaboration between the resident, his/her representative, the physician, the dietitian, and the clinical staff.

The facility failed to ensure R45's offloading boots were applied to both heels to prevent the worsening of pressure ulcers. This placed R45 at increased risk for worsening pressure ulcers and developing new pressure ulcers.

- R29's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), and cerebrovascular accident (CVA-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) affecting the dominate right side.

The "Annual Minimum Data Set" (MDS) dated 02/08/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R29 was independent with transfers, changes in position, and ambulation was not tested. The MDS recorded R29 used a manual wheelchair. The

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MDS documented R29 was at risk for the development of pressure-related injuries. The MDS documented R29 had pressure-reducing devices on his bed and in his chair.

The "Quarterly MDS" dated 08/08/24 documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R29 was independent with transfers, changes in position, and ambulation. The MDS documented R29 was at risk for the development of pressure-related injuries. The MDS documented R29 had pressure-reducing devices on his bed and in his chair.

R29's "Falls Care Area Assessment" (CAA) dated 02/21/24 documented he was at risk for adverse effects.

R29's "Care Plan" dated 02/14/23 documented he had a pressure-reducing mattress on his bed and a pressure-reducing cushion in his wheelchair to prevent skin breakdown.

On 10/15/24 at 10:18 AM R29 sat reclined in his recliner with his call light on the floor at the foot of his bed outside his reach. R29's wheelchair lacked a pressure-reducing cushion.

On 10/17/24 at 11:19 AM, Licensed Nurse (LN) G stated the nursing staff would ensure pressure relieving devices were in place for each of the residents who are at risk for the development of pressure-related injuries. LN G stated that R29 should have a pressure-reducing cushion in his wheelchair.

On 10/17/24 at 11:46 AM, Certified Nurse Aide (CNA) M stated R29 transfers himself at times

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F 686	Continued From page 16 from his wheelchair. CNA M stated she was not sure if R29 should have a pressure-reducing cushion in his wheelchair. On 10/17/24 at 01:00 PM, Administrative Nurse D stated the nursing staff monitors the pressure-reducing devices in place for the residents who are at risk of pressure-related injuries. Administrative Nurse D stated R29 should have a pressure-reducing cushion in his wheelchair if he was at risk for the development of pressure-related injuries. The facility's "Wound Assessment, Prevention, and Treatment" policy dated 11/28/17 documented that a resident who enters the facility without pressure ulcers would not develop them unless the individual's clinical condition demonstrates that they were unavoidable. Residents would be evaluated and monitored to prevent the development of pressure ulcers and to promote rapid healing of any pressure ulcers that are present. A comprehensive, individualized care plan would be developed to address the prevention of pressure ulcers, management of risk factors, and treatment strategies for residents with pressure ulcers. The strategies would be developed through collaboration between the resident, his/her representative, the physician, the dietitian, and the clinical staff. The facility failed to ensure pressure pressure-reducing device was in place in R29's wheelchair. This deficient practice placed R29 at risk of developing pressure ulcers.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		

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§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The sample included 13 residents with two residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 45's palm splint was applied. This deficient practice placed the resident at risk for discomfort and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).

Findings included:

- R45's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of aphasia (condition with disordered or absent language function) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the

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brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting left dominant side, dysphagia (swallowing difficulty), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (a major mood disorder that causes persistent feelings of sadness), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hypertension (HTN-elevated blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Significant Change Minimum Data Set" (MDS) dated 09/02/24 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R45 was dependent on staff for toileting, bathing, and dressing, and was independent with eating.

R45's "Activity of Daily Living Functional / Rehabilitation Potential Care Area Assessment" (CAA) dated 09/02/24 documented R45 could feed herself after staff set-up. R45 was dependent on all other activities of daily living (ADLs). She required a mechanical lift and used a Broda chair (a specialized wheelchair with the ability to tilt and recline).

R45's "Care Plan" dated 06/13/24 documented that staff would remove R45's palm splint twice daily and perform gentle ROM and hand hygiene. R45's plan of care revised on 09/24/24 documented R45 had a left-hand contracture (abnormal permanent fixation of a joint or

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muscle) and would wear a palm splint on her left hand.

R45's EMR reviewed on 10/17/24 lacked documentation or evidence of any refusals to wear the palm splint.

On 10/14/24 at 08:35 AM, R45 sat in her room, in her Broda chair. R45's fingers on her left hand were curled and her hand was closed. R45 did not have her palm splint on her hand.

On 10/15/24 at 08:50 AM R45 sat in her Broda chair watching TV. R45's fingers on her left hand were curled and her hand was closed. R45 did not have her palm splint on her hand.

On 10/17/24 at 10:33 AM Licensed Nurse (LN) G stated she was unaware of a palm sprint for R45. She stated the palm splint was not on her "Treatment Administration Record" (TAR). She stated the CNAs would know if a resident needed a palm splint, by the resident's plan of care.

On 10/17/24 at 11:47 AM Certified Nurse's Aide (CNA)M stated nursing would know if a resident needed special devices by the plan of care. She stated all devices would pull up on each resident's chart. CNA M stated residents' hands should be opened as far as possible and hand splints should be placed daily.

On 10/17/24 at 01:01 PM, Administrative Nurse D stated nursing was responsible for ensuring each resident received any special devices such as splints. Administrative Nurse D stated if a palm splint was on a resident's care plan, the splint would pull up on the CNA's resident plan of care. Administrative Staff D stated R45's splint should

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F 688	Continued From page 20 have been in her left palm, and she should wear the splint as long as tolerated. The facility's "Restorative" policy documented that residents would receive restorative nursing services to promote the ability to adapt and adjust to living as independently and safely as possible. The facility failed to ensure R45 palm splint was placed in her left palm. This deficient practice placed the resident at risk for discomfort and decreased ROM.	F 688		
F 689 SS=E	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 identified a census of 45 residents. The sample included 13 with three reviewed for accidents. Based on observation, record review, and interview the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area, and out of reach of seven cognitively impaired independently mobile residents. The facility additionally failed to ensure fall interventions were implemented per the residents' plan of care for Residents (R)29 and R34. This placed the affected residents at risk for injuries from preventable accidents.	F 689		

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Findings Included:

- On 10/15/24 at 07:04 AM an inspection of the facility Red Hall revealed an unsecured shower room with the door propped open. An inspection of an unlocked closet revealed a spray bottle of multi-purpose cleaner and a bottle of isopropyl alcohol. Both items contained the warning, "Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed."

On 10/15/24 at 07:09 AM Certified Nurse's Aide (CNA) N stated the items should be secured in a locked area.

On 10/17/24 at 01:01 PM Administrative Nurse D stated potentially hazardous chemicals should remain locked up away from the residents. She stated areas that contained potentially hazardous equipment and chemicals should be locked.

The facility's "Chemical and Hazardous Material Storage" policy revised 11/2018 indicated the facility was to ensure all potentially hazardous items were stored in a manner that protected the residents. The policy indicated the bottles were to be stored in a locked area and supervised when in use.

The facility failed to ensure a safe environment free from accident hazards for seven cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries.

- R29's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the

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body), and cerebrovascular accident (CVA-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) affecting the dominate right side.

The "Annual Minimum Data Set" (MDS) dated 02/08/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R29 was independent with transfers, changes in position, and ambulation was not tested. The MDS documented R29 had no falls during the observation period.

The "Quarterly MDS" dated 08/08/24 documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R29 was independent with transfers, changes in position, and ambulation. The MDS documented R29 had no falls during the observation period.

R29's "Falls Care Area Assessment" (CAA) dated 02/21/24 documented he was at risk for adverse effects.

R29's "Care Plan" dated 02/14/23 documented he ambulated short distances with a walker and stand-by assistance of one staff member. The plan of care documented R29 had the ability to roll from side to side but required staff assistance of one staff member to go from lying to a sitting position and from a sitting position to a lying position. The plan of care documented that R29 was able to transfer himself with staff supervision or touch assistance using his walker. The plan of care documented R29 used his wheelchair for transportation and was able to propel himself short distances. The plan of care documented

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R29 wanted to continue to work with physical therapy and occupational therapy to increase his strength and safety with transfers and ambulation. The plan of care dated 04/27/24 documented that staff would encourage him to use his call light and wait for assistance for all his transfers. The plan of care dated 04/29/24 documented that staff would place non-skid strips in front of his recliner. The plan of care dated 05/23/24 documented that antiroll back brakes would be added to R29's wheelchair. The plan of care dated 07/08/24 documented that Dycem (non-slip material) was added to R29's recliner.

A review of R29's EMR under the "Progress Notes" tab revealed a "Nurse Note" dated 04/27/24 at 05:24 PM, documenting that R29 was found on the floor. He stated he had attempted to transfer himself into his wheelchair.

On 05/21/24 at 10:07 AM an "eInteract Situation, Background, Assessment, and Recommendation" (SBAR) note documented R29 was sent to the hospital for an evaluation following a fall.

On 07/07/24 at 04:00 PM a "SBAR" note documented an evaluation for an unwitnessed fall. R29 was found on the floor. R29 had stated he had slid from his chair.

On 09/21/24 at 05:30 AM, an "SBAR" note documented an evaluation for an unwitnessed fall. R29 was unable to state what had happened.

On 10/14/24 at 10:34 AM R29 lay on his bed. His call light lay directly on the floor at the foot of his bed. R29's recliner next to the bed lacked the Dycem.

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On 10/15/24 at 10:18 AM R29 sat reclined in his recliner with his call light on the floor at the foot of his bed outside his reach. R29's recliner lacked the Dycem.

On 10/17/24 at 11:19 AM, Licensed Nurse (LN) G stated everyone's call light should always be within their reach. LN G stated if a resident did not have their call light in reach, that could result in an injury from a fall. LN G stated it was everyone's responsibility to ensure each resident's fall interventions were in place to prevent further falls.

On 10/17/24 at 11:46 AM, Certified Nurse Aide (CNA) M stated R29 was a fall risk. CNA M stated R29 would fall attempting to transfer himself to or from his wheelchair. CNA M stated that R29 had antiroll brakes on his wheelchair and said he should have his call light in his reach.

On 10/17/24 at 01:00 PM, Administrative Nurse D stated expected everyone's call light to within their reach. Administrative Nurse D stated the nursing staff was responsible for ensuring all the fall interventions were in place for each resident.

The facility's "Occurrences" policy dated 11/28/17 documented that the facility would ensure that each resident received adequate supervision and assistive devices to reduce the risk of occurrences. All residents would be assessed for fall risk and those determined to be at risk would have interventions implemented. The interventions would be reviewed periodically and would be revised, or additional ones added as needed. Any accident or occurrence would be thoroughly investigated to rule out abuse and

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neglect and to determine a root cause. Appropriate interventions would be developed based on the root cause analysis.

The facility failed to ensure Dycem was in the recliner per R29's plan of care and failed to ensure his call light was within reach. This deficient practice placed R29 at further risk for injuries related to falls.

R34's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - 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) of the left non-dominant side, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, attention deficit disorder, hypertension (HTN-elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), epilepsy (brain disorder characterized by repeated seizures), and respiratory failure with hypoxia (inadequate supply of oxygen).

The "Admission Minimum Data Set" (MDS) for R34 dated 08/16/24 recorded a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R34 had impairment of one side of her body. The MDS documented R34 needed maximum to substantial assistance with upper and lower body dressing and was dependent on staff for hygiene needs. The MDS documented R34 had no falls since admission.

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R34's "Falls Care Area Assessment " dated 08/16/24 documented R34 was at risk for falls related to left-sided hemiplegia and R34 received hospice services.

R34's "Care Plan" dated 09/04/24 documented R34 was a fall risk and needed assistance with mobility and activities of daily living (ADLs). R34's plan of care dated 09/18/24 documented she did not want to fall during her stay at the facility, and for her safety, she had had a fall mat placed next to her bed. The plan of care documented R34 needed assistance to stand, pivot, and transfer from her bed to a chair. R34's plan of care stated she needed staff to propel her wheelchair and to keep her call light within reach.

On 10/14/24 at 07:05 AM R34 laid in bed on her back, with her right leg hanging off the bed, R34's fall mat lay on top of the empty bed in her room. R34's call light was on the floor.

On 10/15/24 at 07:51 AM R34 laid on her bed on her back. R34's fall mat was folded in half on the empty bed in her room.

On 10/17/24 at 11:33 AM Certified Nurse's Aide (CNA)M stated fall mats should be placed next to the bed, and call lights should be within the resident's reach. CNA M stated she would be able to see who used a fall mat by the resident's plan of care. She stated nursing should have noticed and corrected the fall mat being on top of the extra bed in the resident's room instead of where it belonged.

On 10/17/24 at 11:47 AM Licensed Nurse (LN) G stated all nurses were responsible for ensuring the residents did not fall. She stated the fall mat

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F 689	Continued From page 27 should have been in place next to R34's bed, not on the empty bed. She stated call lights should be on the resident, or within the resident's reach. On 10/17/24 at 01:01 PM Administrative Nurse D stated the fall mat should be in place if the resident was in bed. She stated the CNAs would be able to find the fall intervention information in the resident's plan of care. She stated call lights should always be within reach. The facility's "Occurrences" policy dated 11/28/17 documented that the facility would ensure that each resident received adequate supervision and assistive devices to reduce the risk of occurrences. All residents would be assessed for fall risk and those determined to be at risk would have interventions implemented. The interventions would be reviewed periodically and would be revised, or additional ones added as needed. Any accident or occurrence would be thoroughly investigated to rule out abuse and neglect and to determine a root cause. Appropriate interventions would be developed based on the root cause analysis. The facility failed to ensure R34's fall mat was in place next to her bed and further failed to ensure her call light was within her reach. This deficient practice placed R34 at risk for falls and fall-related injury.	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	F 690		

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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 possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The sample included 13 residents with one resident observed for bowel and bladder. Based on observation, record reviews, and interviews the facility failed to assess, identify, and implement interventions related to Resident(R)31's incontinence. This deficient

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practice placed R31 at risk of impaired dignity and increased risk for urinary tract infections (UTI).

Finding included:

- R31's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary incontinence, overweight, neoplasm (tumor) of right breast, and back pain.

The "Annual Minimum Data Set" (MDS) dated 09/12/24 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented that R31 needed substantial to maximum assistance with toileting hygiene. The MDS documented that R31 did not have a trial of a toileting program. The MDS documented R31 was occasionally incontinent of bladder, and occasionally incontinent of bowel.

R31's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 09/12/24 documented R31 needed assistance with toileting, transfers, and hygiene.

R31's clinical record lacked evidence staff assessed R31's bladder incontinence to evaluate causative factors and voiding patterns.

R31's "Care Plan" dated 09/24/24 documented R31 wanted a licensed nurse to check her skin weekly, and staff to provide a pressure relieving device to her bed and wheelchair. The plan of

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care lacked direction regarding toileting and incontinence care.

R31's EMR under the "Orders" tab revealed the following physician orders:
Keflex (antibiotic) 500 milligrams (mg) every 12 hours times five days for UTI dated 05/16/24.
Macrobid (antibiotic)100 mg by mouth twice a day for UTI dated 06/27/24.
Cefpodoxime (antibiotic) 100 mg oral tabled one tablet by mouth every 12 hours times five days for UTI dated 07/01/24.
Cephalexin (antibiotic) oral tablet 250 mg give one tablet by mouth one time a day related to urinary incontinence for 90 Days dated 09/24/24.

On 10/14/24 at 07:10 AM R31 sat in her wheelchair in the dining room visiting with peers.

On 10/15/24 at 07:26 AM R31 sat in her wheelchair. R31 waited to go to the dining room for breakfast.

On 10/17/24 at 11:33 AM, Licensed Nurse (LN) G stated the nursing staff should toilet residents when the residents wake up, after each meal, before going to bed, and anytime the resident asks to go to the restroom. LN G stated the plan of care for the resident should address toileting and incontinence. She stated that if staff did not know when a resident needed to be toileted, that could cause urinary tract infections if the resident was sitting in a wet brief or retaining urine.

On 10/17/24 at 11:47 AM, Certified Nurse Aide (CNA)M stated there was usually a toileting schedule for all residents She stated if there was not a schedule, the staff would ask the resident or wait until the resident put on their call light. CNA

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F 690	Continued From page 31 M stated nursing staff would know how often the residents should be toileted, and how much help the residents needed for toileting, by their plan of care. On 10/17/24 at 01:01 PM, Administrative Nurse D stated bladder incontinence and toileting schedules should be addressed in the plan of care for each resident. Administrative Nurse D stated if a toileting program was anticipated, the resident's book would be at the nurse's station for CNAs to document when the resident voided. The facility did not provide a urinary incontinence policy. The facility failed to assess, identify, and implement interventions to address R31's incontinence. This deficient practice placed R31 at risk of complications and further UTIs.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the	F 695		

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facility failed to ensure Resident(R) 21's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored in a sanitary manner. This placed R21 at an increased risk for respiratory infection and complications.

Findings included:

- R21's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), thrombocytopenia (abnormally low number of platelets, the parts of the blood that help blood to clot, sometimes associated with abnormal bleeding), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The "Admission Minimum Data Set" (MDS) dated 07/30/24 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R21 needed partial to moderate assistance with toileting, bathing, and dressing. The MDS documented R21 used a CPAP during the observation period.

R21's " Activities of Daily Living/Rehabilitation Potential Care Area Assessment" (CAA) dated 07/30/24 documented R21's goal was to go home.

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R21's "Care Plan" focus for diabetes dated 08/24/24 documented that nursing staff were to monitor R21's blood glucose as ordered by my physician and as needed. R21's focus for respiratory lacked any interventions or direction related to R21's respiratory equipment including her CPAP.

R21's EMR under the "Orders" tab revealed the following physician orders:

Nursing was to change oxygen (O2) tubing and rinse the filter every week on Wednesday for oxygen use; nursing was to date the tubing when changed and to add the number of liters ordered for the resident to the sticker on the tank dated 07/31/24.

Albuterol inhalation solution (medication inhaled to open airways) 2.5-3.0 give 3 milligrams (mg)per 3 milliliters (ml) nursing to give one vial nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) every six hours for wheezing as needed and shortness of breath, dated 07/23/24.

CPAP at bedtime is related to obstructive sleep apnea (a sleep disorder that occurs when the throat muscles relax and narrow the airway during sleep, interrupting breathing) in the evening and off in the morning. Clean CPAP every Tuesday once a week dated 07/26/24.

On 10/15/24 at 08:33 AM R21 sat in her chair, talking to her peer. R21's CPAP lay in the middle of her bed, and R21's CPAP mask was not stored in a sanitary container.

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F 695	Continued From page 34 On 10/15/24 at 02:50 PM, R21 sat in her chair and visited. R21's CPAP lay in the middle of her bed with a blanket thrown over her mask. R21's CPAP mask was not stored in a sanitary container. On 10/17/24 at 11:33 AM Licensed Nurse (LN)G stated all respiratory equipment should have a covering, or be placed in a bag, and the bag should be dated. On 10/17/24 at 11:47 AM, Certified Nurse's Aide (CNA) M stated staff should place the CPAP mask on the bedside table. CNA M did not believe the CPAP mask would need any type of container. On 10/17/24 at 01:01 PM, Administrative Nurse D stated all respiratory equipment should be contained when not in use. She stated the bags should have the resident's name and date on the bag. The facility did not provide a policy for sanitary storage of respiratory equipment. The facility failed to ensure R21's CPAP mask was stored in a sanitary manner. This placed R21 at an increased risk for respiratory infection and respiratory complications.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed	F 700		

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rails, including but not limited to the following elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The sample included 13 residents with three residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Residents (R)12 and R46 had a documented safety assessment for the use of side rails that addressed entrapment, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the residents at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.

Findings Included:

- The "Medical Diagnosis" section within R12's Electronic Medical Records (EMR) noted diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), aphasia

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(difficulty speaking), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion).

R12's "Quarterly Minimum Data Set" (MDS) dated 08/08/24 documented a Brief Interview of Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated he had no upper and lower extremity impairments. The MDS indicated he was dependent on staff assistance for oral hygiene, bed mobility, toileting, bathing, dressing, and transfers. The MDS indicated he had no side rails.

R12's "Functional Abilities Care Area Assessment (CAA)" completed 11/27/23 indicated he required staff assistance for all his activities of daily living (ADLs). The CAA noted a care plan would be completed to minimize the risks.

R12 "Care Plan" initiated 07/18/19 indicated he required extensive assistance from staff for dressing, personal hygiene, bathing, toileting, bed mobility, and transfers. The plan noted he required the use of a Hoyer lift (full-body mechanical lift) and two staff for all transfers. The plan noted he used quarter rails when being transferred in and out of bed.

R12's EMR under the "Assessments" tab revealed a "Quarterly Assessment" completed on 08/08/24. The assessment included a Bed Mobility Device evaluation that indicated R12 had quarter-side rails installed on his bed for mobility. The evaluation noted the rails were used to assist him with bed positioning. The evaluation did not acknowledge the use of R12's low air-loss mattress.

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R12's EMR lacked evidence of a safety assessment for the use of his side rail which addressed the risk of entrapment between the device and the mattress, consent for the use, and documentation that the resident and/or responsible party were advised of the risks and/or benefits of the use of the bed rails. The facility was unable to provide this documentation as requested on 10/17/24.

A review of the low air-loss mattress manufacturer's operation (Drive Model #14000 Series) manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment.

On 10/15/24 at 08:03 AM R12 rested in his bed. His bed had bilateral side rails in the up position. R12's bed had a low air-loss mattress system.

On 10/17/24 at 11:45 AM Certified Nurse's Aide (CNA) M stated staff checked to ensure the bed rails had no gaps and would notify the nurses of any concerns found.

On 10/17/24 at 12:04 PM Licensed Nurse G stated the bed rails should be assessed every quarter for safety but checked by staff each time they enter the room.

On 10/17/24 at 01:01 PM, Administrative Nurse D stated the facility completed bed rail assessments with each quarterly, annual, and significant change nursing assessment. She stated the evaluation should include the type of rail used, reason for use, risks associated with use, and type of bed the resident required to include low air-loss mattresses.

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The facility's "Bed Mobility Device" revised 11/2017 indicated all residents would be assessed for the need for bed mobility devices. The policy noted the bed mobility device assessments would be completed on admission, readmission, quarterly, and with significant changes. The policy noted the assessments would be completed before the utilization of the devices.

The facility failed to ensure that R12 had a safety assessment for the use of side rails that acknowledged the risks from the low air-loss mattress, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed R12 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.

- The "Medical Diagnosis" section within R46's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), restlessness, and agitation.

R46's "Significant Change Minimum Data Set" (MDS) dated 08/06/24 documented a Brief Interview of Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated she had upper and lower extremity impairments. The MDS indicated she required supervision or touch assistance from staff assistance for oral hygiene, bed mobility, toileting,

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bathing, dressing, and transfers. The MDS indicated she had no bed rails. The MDS indicated she weighed 156 pounds (lbs.).

R46's "Falls Care Area Assessment (CAA)" completed on 08/07/24 indicated she was at risk for falls related to her limited mobility and medical diagnoses. The CAA noted she had previous falls, and a care plan would be completed to minimize the risks.

R46's "Care Plan" initiated 05/02/24 indicated she required supervision and sometimes touch assistance with transfers, bed mobility, ambulation with her walker, personal hygiene, toileting, and bathing. The plan did not acknowledge her bed's bilateral side rails.

R46's EMR under the "Assessments" tab revealed a "Quarterly Assessment" completed on 07/29/24. The assessment included a Bed Mobility Device evaluation that indicated R46 had quarter-side rails installed on her bed for mobility. The evaluation noted the rails were used to assist her with bed positioning. The evaluation did not acknowledge the use of R46's low air-loss mattress.

R46's EMR lacked evidence of a safety assessment for the use of his side rail which addressed the risk of entrapment between the device and the mattress, consent for the use, and documentation that the resident and/or responsible party were advised of the risks and/or benefits of the use of the bed rails. The facility was unable to provide this documentation as requested on 10/17/24.

A review of the low air-loss mattress

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manufacturer's operation (Drive Model #14000 Series) manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment.

On 10/15/24 at 12:19 PM, R46 lay in her bed with her lunch tray pulled up over her waist. Her bed had bilateral side rails in the up position. R46's bed had a low air-loss mattress system. The weight was set to 300 lbs.

On 10/17/24 at 11:45 AM Certified Nurse's Aide (CNA) M stated staff checked to ensure the bed rails had no gaps and would notify the nurses of any concerns found.

On 10/17/24 at 12:04 PM Licensed Nurse G stated the bed rails should be assessed every quarter for safety but checked by staff each time they enter the room.

On 10/17/24 at 01:01 PM, Administrative Nurse D stated the facility completed bed rail assessments with each quarterly, annual, and significant change nursing assessment. She stated the evaluation should include the type of rail used, reason for use, risks associated with use, and type of bed the resident required to include low air-loss mattresses.

The facility's "Bed Mobility Device" revised 11/2017 indicated all residents would be assessed for the need for bed mobility devices. The policy noted the bed mobility device assessments would be completed on admission, readmission, quarterly, and with significant changes. The policy noted the assessments will be completed before the utilization of the devices.

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F 700	Continued From page 41 The facility failed to ensure that R46 had a safety assessment for the use of side rails that acknowledged the risks from the low air-loss mattress, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed R46 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents.	F 757		

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The sample included 13 residents with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to notify Resident (R)21's physician according to the physician-ordered parameters for blood glucose monitoring. This deficient practice placed R21 at risk for delayed treatment of hyperglycemia (greater than the normal amount of glucose in the blood) and unnecessary medication complications.

Findings included:

- R21's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), thrombocytopenia (abnormally low number of platelets, the parts of the blood that help blood to clot, sometimes associated with abnormal bleeding), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The "Admission Minimum Data Set" (MDS) dated 07/30/24 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R21 needed partial to moderate assistance with toileting, bathing, and dressing. The MDS documented R21 had DM. The MDS documented R21 received insulin (a hormone that lowers the level of glucose in the blood)

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during the observation period.

R21's " Activities of Daily Living/Rehabilitation Potential Care Area Assessment" (CAA) dated 07/30/24 documented R21's goal was to go home.

R21's "Care Plan" initiated on 08/28/24 documented R21 wanted her blood glucose levels to remain within the parameters set by her physician. Nursing was to administer her insulin as ordered by her physician. The plan of care documented that if R21's blood glucose level was greater than 300 milliliters (ml) per deciliter (dL) or less than 70 ml/dl, nursing was to notify the physician. R21's plan of care documented nursing was to monitor R21's blood glucose as ordered by her physician and as needed (PRN).

R21's EMR under "Orders" revealed the following physicians' orders:
Blood Glucose monitoring in the morning, notify the physician if blood glucose was greater than (>) 300 ml/dl or less than (<) 70 ml/dl, and as needed for elevated blood sugars dated 07/23/24.
Basaglar insulin (long-acting insulin) Kwik Pen inject 10 units at bedtime for DM; notify the physician if blood glucose is greater than 300 ml/dl or less than 70 ml/dl dated 09/01/24.
Novelin insulin (fast-acting insulin) injection solution injects as per sliding scale: if 70 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 500 = 12 units 401 and higher give 12 units AND call physician, two times a day for DM dated 09/06/24.
Basaglar insulin Kwik Pen solution, inject 30 units in the morning for diabetes dated 09/20/24.

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R21's EMR under the "Treatment Administration Record (TAR)" recorded the following blood glucose levels above 400 ml/dl that lacked evidence the physician was notified:
09/09/24 478 ml/dl,
09/12/24 410 ml/dl
09/13/24 420 ml/dl
09/22/24 412 ml/dl

R21's EMR under TAR documented R21's blood glucose was over 300 on 08/22/24, 09/01/24, 09/07/24, 09/09/24, 09/10/24, 09/11/24, 09/14/24, 09/15/24, 09/18/24, 09/20/24, 09/21/24, 09/23/24, 09/24/24, 09/27/24, 10/02/24, 10/05/24, and 10/06/24. R21's clinical record lacked indication R21's physician was notified of the elevated blood glucoses.

On 10/15/24 at 07:33 AM R21 sat in his wheelchair eating breakfast and visiting with peers.

On 10/17/24 at 11:47 PM Licensed Nurse (LN) G stated it was the nurse's duty to follow up with the physician for all blood glucose readings outside of the parameters given by the physician. She stated if the glucose reading was over 300 ml/dl, nursing should have called the physician.

On 10/17/24 at 01:01 PM Administrative Nurse D stated the order to call the physician if the blood glucose was over 300 ml/dl was the facility's order. She stated the facility places the standing order to ensure nurses are paying close attention to blood glucose readings. Administrative Nurse D stated she would expect nursing to call the physician if any glucose reading was over 300 ml/dl.

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F 757	Continued From page 45 The facility did not provide a policy for blood glucose monitoring. The facility failed to notify R21's physician of blood glucose outside the ordered parameters for glucose monitoring related to insulin use. This deficient practice placed R21 at risk for complications related to hyperglycemia and unnecessary medications.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		

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§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 45 residents. The sample included 13 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R)34 and R32 had a stop date for as-needed (PRN) lorazepam (anxiety medication). This placed the residents at risk for adverse effects from psychotropic (alters mood or thoughts) medication.

Findings included:

- R34's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - the sudden death of brain cells

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due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) of the left non-dominant side, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, attention deficit disorder, hypertension (HTN-elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), epilepsy (brain disorder characterized by repeated seizures), and respiratory failure with hypoxia (inadequate supply of oxygen).

The "Admission Minimum Data Set" (MDS) for R34 dated 08/16/24 recorded a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R34 had impairment of one side of her body. The MDS documented R34 needed maximum to substantial assistance with upper and lower body dressing and was dependent on staff for hygiene needs. The MDS documented R34 received antianxiety medications during the observation period.

R34's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 08/16/24 documented R34 was at risk for adverse side effects.

R34's "Care Plan" dated 09/04/24 documented R34 had depression and anxiety and did not want adverse effects from psychotropic medications, and nursing staff would give her medications as ordered by the physician. R34's plan of care documented that staff were to watch for any side effects of R34's antidepressant and antianxiety medications.

R34's EMR under the "Orders" tab revealed the

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following physician's orders:
Ativan (lorazepam-antianxiety medication) tablet give 0.5 milligrams (mg) by mouth every four hours PRN for anxiety for end-of-life care. Nursing staff to apply nonpharmacological interventions before administration dated 09/27/24. R34's order did not indicate a stop date for the PRN lorazepam.

On 10/15/24 at 07:53 AM, R34 lay in her bed, awaiting her breakfast.

On 10/17/24 at 08:34 AM R34 laid in her bed. R34 was visiting with the nursing staff.

On 10/17/24 at 11:19 AM, Licensed Nurse (LN) G stated that PRN lorazepam should have a 14-day stop date. LN G stated the nurse who enters the order should enter the 14-day end date on the order.

On 10/17/24 at 01:00 PM, Administrative Nurse D stated she expected all PRN lorazepam orders to have an automatic 14-day stop date placed on the order unless a specific duration of time was ordered by the physician with the documentation for the continued use beyond the 14-day stop date.

The facility's "Psychoactive Medications" policy dated 11/28/17 documented psychoactive medications include antipsychotics, anti-anxiety, antidepressants, and hypnotics/sedatives. As needed antianxiety, antidepressant, hypnotic, and sedative medication had a time limitation of 14 days. An order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it was appropriate to extend the order. Required actions: The attending

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physician or prescribing practitioner must document the rationale for the extended duration in the medical record and indicate a specific duration.

The facility failed to ensure R34 had a stop date for PRN lorazepam This placed the R34 at risk for unnecessary medication administration and possible adverse side effects.

- R32's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of amyotrophic lateral sclerosis (ALS-a progressive neurological disorder that causes the gradual death of nerve cells in the brain and spinal cord, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Admission Minimum Data Set" (MDS) dated 07/25/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R32 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication and antidepressant (a class of medications used to treat mood disorders) medication during the observation period.

R32's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 08/01/24 documented she was at risk for side effects.

R32's "Care Plan" dated 07/22/24 documented staff would monitor for adverse reactions and notify the physician.

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R32 's EMR under the "Orders" tab revealed the following physician orders:
Lorazepam (antianxiety medication) intensol concentrate two mg/milliliter (ml) give 0.25 ml every four hours as needed for anxiety or shortness of air dated 10/11/24. The as-needed antianxiety medication lacked a 14-day stop date or a physician-ordered specific duration.

On 10/15/24 at 12:22 PM R32 laid on her bed as she ate her lunch.

On 10/17/24 at 11:19 AM, Licensed Nurse (LN) G stated the as-needed lorazepam should have a 14-day stop date. LN G stated the nurse who enters the order should enter the 14-day end date on the order.

On 10/17/24 at 01:00 PM, Administrative Nurse D stated she expected all as-needed lorazepam orders to have an automatic 14-day stop date placed on the order unless a specific duration of time was ordered by the physician with the documentation for the continued use beyond the 14-day stop date.

The facility's "Psychoactive Medications" policy dated 11/28/17 documented psychoactive medications include antipsychotics, anti-anxiety, antidepressants, and hypnotics/sedatives. As needed antianxiety, antidepressant, hypnotic, and sedative medication had a time limitation of 14 days. An order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it was appropriate to extend the order. The attending physician or prescribing practitioner must document the rationale for the extended duration in the medical record and indicate a specific duration.

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F 758	Continued From page 51 The facility failed to ensure R32's as-needed lorazepam had a stop date or a physician-ordered specified duration for administration. This placed R32 at risk for unnecessary medication administration and possible adverse side effects.	F 758		
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to ensure that physician-ordered laboratory test results for Resident (R) 31 were included in R31's clinical record. This deficient practice could result in unnecessary tests and delayed treatment. Findings included: - R31's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary incontinence, overweight, neoplasm (tumor) of right breast, and back pain. The "Annual Minimum Data Set" (MDS) dated 09/12/24 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated	F 775		

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moderately impaired cognition. The MDS documented that R31 needed substantial to maximum assistance with toileting hygiene. The MDS documented that R31 did not have a trial of a toileting program. The MDS documented R31 was occasionally incontinent of bladder, and occasionally incontinent of bowel.

R31's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 09/12/24 documented R31 needed assistance with toileting, transfers, and hygiene.

R31's "Care Plan" dated 09/24/24 documented R31 wanted a licensed nurse to check her skin weekly, and staff to provide a pressure relieving device to her bed and wheelchair. The plan of care lacked direction regarding toileting and incontinence care.

R31's EMR under the "Nursing Communication Notes" documented urine analyses were ordered on 05/14/24, 06/16/24, and 09/12/24 for possible urinary tract infection (UTI).

A review of R31's clinical record lacked evidence of the culture and sensitivity results for the urinalysis test ordered by the physician.

The facility provided unsigned copies of the culture and sensitivity results upon request on 10/15/24.

On 10/14/24 at 07:10 AM R31 sat in her wheelchair in the dining room visiting with peers.

On 10/15/24 at 10:05 AM, Administrative Nurse D stated the cultures were sent to the physician from the lab for review; the nurses called the

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PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

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F 775	Continued From page 53 physician to follow up on all lab results. She stated the cultures were supposed to be scanned into the resident's medical record. She verified that R31's cultures had not been scanned into the resident medical record. The facility did not provide a policy related to laboratory tests. The facility failed to ensure that physician-ordered laboratory test results for R31 were included in R31's clinical record. This deficient practice could result in unnecessary tests and delayed treatment.	F 775		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and	F 849		

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to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual

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F 849	Continued From page 55 resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the	F 849		

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LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

(E) Instructions on how to access the hospice's 24-hour on-call system.

(F) Hospice medication information specific to each patient.

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(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The sample included 13 residents with two residents reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)45. This placed the resident at risk for inappropriate end-of-life care.

Finding Included:

- R45's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of aphasia (condition with disordered or absent language function) following cerebral infarction (stroke - sudden death of brain cells due to lack

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of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting left dominant side, dysphagia (swallowing difficulty), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hypertension (HTN-elevated blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Significant Change Minimum Data Set" (MDS) dated 09/02/24 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R45 was dependent on staff for toileting, bathing, and dressing, and was independent with eating. The MDS recorded R45 received hospice care.

R45's " The Activity of Daily Living Functional /Rehabilitation Potential Care Area Assessment" (CAA) dated 09/02/24 documented R45 could feed herself after staff set-up. R45 was dependent on all other activities of daily living (ADLs). She requires a mechanical lift and uses a Broda chair (a specialized wheelchair with the ability to tilt and recline).

R45's "Care Plan" dated 09/24/24 documented that staff would coordinate R45's care with the hospice staff to ensure all her needs were being met. R45's plan of care documented that hospice

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would provide comfort medications. R45's plan of care documented that staff would need to help and ensure R45 could spend quality time with her family and that they were helped to feel comfortable. R45's plan of care did not include what services hospice would provide, such as medication, supplies, or frequency and availability of hospice worker visits.

A review of the hospice-provided communication binder revealed that R45 was admitted to hospice services on 08/26/24.

R45's "Hospice Plan of Care" developed by hospice and provided to the facility included a section for medication but none were listed. There was a section for DME [durable medical equipment] and Supplies which listed incontinence and hygiene supplies as well as gloves.

On 10/14/24 at 08:35 AM, R45 sat in her room, in her Broda chair, and visited.

On 10/17/24 at 11:33 AM Licensed Nurse (LN) G stated she was unsure what hospice provided for R45. LN G stated she did not think what hospice provided would need to be on the facility's care plan for the resident. LN G stated hospice aides and nurses would tell the facility what equipment and supplies they brought to the resident.

On 10/17/24 at 11:47 AM Certified Nursing Aide (CNA) M stated she was unsure what hospice provided for the residents. She stated the hospice aides would let the staff know if the hospice provider left any supplies or gave a shower. CNA M stated she didn't think what hospice provided to R45 was on the CNA plan of care.

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F 849	Continued From page 60 On 10/17/24 at 01:01 PM, Administrated Nurse D said she knew the hospice providers developed detailed care plans and the facility staff would know specific services by those. She stated she thought everything hospice provided should be on the care plan, so staff know who to call and when the hospice staff were to be at the facility. The facility's "Hospice and End of Life" policy documented Social Services would meet with the resident, family, and resident representative to discuss options for end-of-life service including hospice. A significant change in status assessment will be initiated and the plan of care will be updated to reflect coordination of care and services with hospice. The facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for R45. This placed the resident at risk for inappropriate end-of-life care.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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

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by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The facility identified five residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP and personal protective equipment (PPE) for Resident (R) 7 and R32. The facility additionally failed to store respiratory equipment in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases.

Included Findings:

- On 10/14/24 at 07:05 AM a walkthrough of the facility was completed with the following observations noted:
An inspection of R7's room revealed no EBP indicator signage or personal protective

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equipment in or around her room related to her wounds.
An inspection of R32's room revealed no EBP indicator signage or personal protective equipment in or around her room related to her Foley catheter (a tube inserted into the bladder to drain urine into a collection bag).

On 10/15/24 at 07:28 AM an inspection of R34's room revealed her wheelchair's supplemental oxygen tank tubing and nasal cannula rested on the seat of her wheelchair. No sanitary storage bag was present.

On 10/17/24 at 11:42 PM, Certified Nurse's Aide (CNA) M stated all oxygen tubing and equipment should be stored in a clean plastic bag to prevent contamination and respiratory infections. She stated that EBP meant taking extra steps to ensure the resident was not exposed to other diseases. She was not sure what the precautions meant but would ask the nurse.

On 10/17/24 at 11:45 PM, Licensed Nurse (LN) G stated any resident with open wounds or stoma (surgical opening), or catheters should be on EBP. She stated signs should be posted outside the rooms and PPE readily available during care.

On 10/17/24 at 01:01 PM Administrative Nurse D stated EBP signage should be placed outside of each room. She stated that R32's neighbor had an EBP signage and moved to another hallway. She stated staff took the sign for R32 resulting in no signage. She stated all respiratory equipment and masks were to be stored in a clean manner and use a clean plastic bag when not in use.

The facility's "CPAP and Oxygen Equipment"

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F 880	Continued From page 64 policy revised 11/in 2017 indicated all respiratory equipment will be maintained and stored in a sanitary manner to prevent contamination and the spread of disease. The facility's "Enhanced Barrier Precautions" policy revised 04/2024 indicated the facility will identify and assess individuals at risk for infections related to open wounds or bacterial colonization. The policy stated the facility would provide the appropriate PPE including gowns and gloves to use during high-contact care. The policy noted the facility will utilize "High Contact Care" signage for residents on EBP. The facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP and PPE. for R7 and R32. The facility additionally failed R21's respiratory equipment in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases.	F 880		
F 883 SS=E	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 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;	F 883		

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F 883	Continued From page 65 (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 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	F 883		

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contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 45 residents. The sample included 13 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to obtain consent or declinations for the Pneumococcal Conjugate Vaccine (PCV20-vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Resident (R) 32, R10, R46, and R34. This placed the residents at increased risk for complications related to pneumonia.

Findings included:

- Review of R32's clinical record revealed the PCV13 was administered on 11/09/23. R32's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration.

A review of R10's clinical record revealed the PCV13 was administered on 10/24/19. R10's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration.

A review of R46's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of any historical administration.

A review of R34's clinical record revealed the PCV13 was administered on 02/03/14 and the PPSV23 was administered on 06/06/15. R34's clinical record lacked documentation the PCV20 was offered or declined and lacked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(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 883	Continued From page 67	F 883		

documentation of a historical administration or a physician-documented contraindication.

On 10/15/24 at 10:45 AM Administrative Nurse D, the facility's Infection Preventionist, stated she had not started offering and getting consent for the PCV20. Administrative Nurse D stated she had been talking with the physician regarding who he wanted to receive and who needed the PCV20.

The facility's "Immunizations: Pneumococcal" policy is documented at the time of admission, the resident, resident representative, or attending physician will be contacted to obtain a history of previous pneumococcal vaccination. PCV13 and PPSV23 vaccines will be available. At that time, they will be provided a copy of the CDC vaccination information summary (VIS) to provide them with risk information. In the event of non-availability of the vaccine beyond the facility's control, standard precautions will continue to be followed for the health and well-being of the residents. Residents will be offered the vaccination as soon as available.

The facility failed to offer the PCV20 or obtain informed declinations for R32, R10, R46, and R34. This placed the residents at increased risk for complications related to pneumonia.