STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175078	A. Building B. Wing	05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46960 The facility reported a census of 70 residents with 18 selected for review. Based on interview, observation, and record review, the facility failed to protect the privacy and dignity of Resident R42. This deficient practice led to R42 being able to be around multiple other residents with visibly soiled clothing. Findings included: - On 04/24/23 at 11:39 AM, R42 observed in a wheelchair in his room wearing pants that were visibly wet. R42 stated he was unable to get into the bathroom in his room, so he was going to try find one somewhere else. R42 self-propelled down the hallway, past two staff members, and into the dining area without staff intervention to change his brief or his pants. On 05/01/23 at 08:32 AM, Certified Nurse Aide (CNA) D revealed R42 normally wore briefs and was to be checked and changed every two hours. On 04/24/23 at 10:25 AM, a strong odor of urine was present halfway down the hallway in the special care unit, with the strongest odor noted outside R52's room. On 04/25/23 at 08:31 AM, a strong odor of urine was present in the hallway immediately outside of R52's room. On 04/25/23 at 09:00 AM, R52 sat in the dining area with other residents with a faint odor of urine present on/around the resident. On 04/27/23 at 03:30 PM, observation of R52's room revealed the point of origin for the odor of urine to be the cloth chair in the room and the clothes hamper inside the closet. On 05/01/12 at 08:28 AM, a strong odor of urine was present in hallway immediately outside of R52's room. On 04/27/23 at 04:40 AM, CNA E revealed she was unaware of the odor of urine on/around R52's room. On 05/01/23 at 08:52 AM, CNA D stated that R52's family did his laundry once per week. CNA D further stated housekeeping staff cleaned his room daily. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/23 at 10:00 AM, Housekeeping Staff F stated staff cleaned R52's room daily but did not know if the chair had ever been deep cleaned to remove the odor. On 05/01/23 at 01:07 PM, Housekeeping Staff G stated the chair in R52's room belonged to him, and that the facility lacked an upholstery cleaner to be able to clean it adequately and appropriately. Housekeeping Staff G stated housekeeping staff wiped the chair with germicidal wipes whenever they did their daily cleaning. Additionally, she stated she has used all of the air freshener products she has available to try to control the odor, without success. On 05/01/23 at 09:18 AM, Licensed Nurse (LN) C revealed R52 retrieved his soiled clothes from the clothes hamper and put them on, then refused to change when asked by staff. LN C further revealed the resident's family was called to assist staff to convince the resident to change out of soiled clothes. On 05/01/23 at 09:18 AM Licensed Nurse (LN) C stated that R42 was supposed have his brief checked every two hours and changed if needed. On 05/01/23 at 02:56 PM, Administrative Nurse B revealed frequently retrieved his soiled clothes from the clothes hamper and refused to take them off. Administrative Nurse B stated that no measures were taken to secure R52's soiled clothes. Additionally Administrative Nurse B stated she did not know whether or not the facility had the appropriate equipment to clean the cloth chair in R52's room. The facility failed to provide a policy for dignity as requested on 05/01/23. The facility failed to protect the privacy and dignity of R52 and R42. This deficient practice led to R42 being able to be around multiple other residents with visibly soiled clothing and R52 living in a malodorous environment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46960 The facility reported a census of 70 residents. Based on observation and interview, the facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in resident areas including on five of the five resident hallways, the dining room, the beauty shop, and in courtyards, for the residents of the facility. Findings included: - Environmental tour of the facility, on 05/01/23 from 02:00 to 04:00 PM, with maintenance staff Z revealed the following resident accessible areas in need of housekeeping/maintenance services: 100 Hallway: The hallway lower walls, across multiple resident room entrances/doors, contained various sized areas of scraped off paint and gouges. The nurses' station/medication preparation room door stood open, and the coded door lock on it, lacked about half of the push-button numbers to the lock. The room had multiple areas over all the walls that lacked paint with scrapes and gouges into the walls. The wall inside to the left behind the medication cart, contained an electrical outlet which had one entire side broken off and missing, leaving an open void into the wall. A small, indented ROOM area, contained a small refrigerator and shelves which were covered with a layer of soiling. The entire floor contained a thick layer of dirt/debris. The corners in the refrigerator area contained scrapes on the corners/sides leaving metal exposed. 200 Hallway: The hallway lower walls, across multiple resident room entrances/doors, contained various sized areas of scraped off paint and gouges. One resident room contained window blinds with the blinds torn off the right window on the lower section and the left window blinds contained multiple areas of bent and missing blinds on the lower section. The far exit fire door contained a code to enter/exit. A folded blanket lay along the front of the door and pushed up under the door, which exposed a void under the door. From the outside of this door the blanket was visible with the entire lower section, approximately 5 to 6 inches missing. The wood above the blanket up approximately two and half feet lacked boards where had pulled off from the door and lay under the bushes next to the door. Maintenance staff Z verified with another unidentified staff that the courtyard from this door was not currently used by residents but that a supply truck would back up to the courtyard gate to unload supplies into the building through this door. Maintenance staff Z explained he was just hired at the facility on 04/17/23 and was still identifying areas/items in need of his services. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A residents shower/toilet room on this hallway contained a layer of dust/debris across the floor areas of the room. 300 Hallway: The hallway lower walls, across multiple resident room entrances/doors, contained various sized areas of scraped off paint and gouges. The residents' phone room contained a low bed without linens, approximately 10 inches high, two soiled intravenous pumps and poles and a round table with a telephone in the middle of the room. The room held no available seating spaces or chairs available for the residents to use to make phone calls. The floor in this room contained a layer of dirt/debris. The far exit doorway went into the smoking courtyard. A facility garage, just on the other side of the fence, had a piece of guttering hanging down above the small walk-in door on the facility side. 400 Hallway: The hallway lower walls, across multiple resident room entrances/doors, contained various sized areas of scraped off paint and gouges. The hallway contained the facility special care unit with a resident census of 9. An unlocked residents' shower/toilet room contained multiple resident care items and personal belonging stored in the room's shower areas. The contents stored included pictures, suitcases, clothes, a wheelchair, two large plastic barrels, window blinds against the wall, decor items, and an oxygen tank caddy. On the far side of the room curtains surrounded the toilet in the room. However, the toilet held signs saying out of order on them. The toilet held a large amount of bowel movement. Maintenance staff Z reported he had not been aware of the broken toilet. He explained the staff were to fill out small pieces of paper with work requests and put them in a basket for him. The exit door from the special care unit contained a newly installed coded door. However, the wall around this door contained wooden framing for the door but no drywall over the outside of it. Maintenance staff Z verified the newly installed door and explained he still needed to complete the job on the wall for that side. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The special care unit's activity/snack room area contained a sink with cabinets along one side wall of the room. A cabinet door under the sink lacked a lower hinge and the door swung outward and only hung by the upper hinge. Under the sink lay a pile of white towels with yellow/brown stains such as a leak of water under the sink. On top of the towels sat a Mr. Coffee coffee maker with approximately two inches of coffee in the pot. One drawer pulled out and the entire bottom of the drawer could be seen down inside of the cabinet below and the entire frame to the drawer loosely flexed back and forth. Other cabinets and drawers in the area contained resident items such as sugar packets, sweeteners, and such, with a layer of debris in the bottom of the drawers. All cabinets/drawers contained jumbled items used for the residents and in no type of order. The room held four lights on the ceiling, and the two on the far side of the room failed to function. Maintenance staff Z explained he had been trying to figure out the problem but had not gotten the lights to work yet. An exit door into the courtyard had the lower approximately two feet of wood peeling and off the outside of the exit door. The small section of the hallway outside of the special care unit contained the various scrapes of missing paint. This section also held the unlocked facility beauty shop. The beauty shop had a layer of dirt/debris over the floor and a beauty shop chair with cracks in the vinyl over the arms and seat. 500 Hallway: The hallway lower walls, across multiple resident room entrances/doors, contained various sized areas of scraped off paint and gouges. An unlocked linen closet, contained 2 packages of incontinent briefs and a rubber type mat that lay directly on the floor. The floor contained visible dirt/debris. A mechanical lift sat in the hallway with a thick layer of dirt/debris over the entire lift. An unlocked, medication preparation room, contained a strong foul odor, and was stacked with soiled resident care equipment, including four mattresses with visible soiling and extensive wear on the coating. The counter just inside the doorway held recent shaving supplies. An unlocked, soiled utility room, contained a strong foul odor, and was stacked with soiled resident care equipment, including parts to a mechanical Hoyer lift with visible rust on some of the parts, two commodes, janitor cart, soiled air mattress with motor, and a walker. This room also held two large plastic barrels with noted trash in them. However, the lids remained off the tops and lay beside them, letting a very foul odor into the room. The hallway's locked northeast exit door into a courtyard, had dirty streaked windows you could see outside. The outside doorway entrance contained about two feet high with dead leaves blown up against the door. The outside under the eve overhangs, approximately four feet on each side, had hanging down and rotting wood. In these areas were also noted wiring which hung downward also. The hallway's locked northwest exit door into a small courtyard contained windows. Outside of the door was the visible eve overhangs, approximately four feet on each side which contained rotting and hanging down wood. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dining Room: An area under the bird aviary (cage), of the flooring, approximately 6 by 8 feet contained multiple areas of deep scratches or cuts into the flooring. The floor in the dining room contained a layer of discoloration/debris with build-up along the wall edgings. The snack area room, where staff went to the kitchens window to obtain meal trays for residents, entire floor was covered in a thick layer of dirt/debris with areas leading to the window of muddy shoes appearance prints. One of the corners to the entrance of this area was a pillar. The pillar contained an unknown substance with appearance of putty, like someone tried to fill in the broken edges of it. The room held the ice machine with a thick layer of dirt/debris under it also. A front resident television/piano room, floor contained the thick layer of discoloration, dirt/debris. The seat to the piano was scratched and worn off over the top. A wheelchair scale sat in the middle of the floor as a staff member brought residents in and out to obtain weights. The floor of the scale contained a layer of dirt/debris over it also. The facility policy, Cleaning and Disinfection of Environmental Surfaces, dated 06/2009, instructed the staff to follow CDC (Center for Disease Control) recommendations. The facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in resident areas for the residents of the facility.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46960 The facility reported a census of 70 residents. The review included 14 facility self-reported incidents with allegations of resident-to-resident abuse, between the dates of 11/10/21 and 04/21/23. Based on observation, interview, and record review the facility failed to provide a safe and secure living environment for the residents of the facility with the failure to accurately investigate, assess, and implement adequate immediate interventions to prevent the continued abuse of resident-to-residents, following these 14 incidents reviewed. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. Findings included: - During the onsite health resurvey, the following 14 facility reported incidents regarding allegations of resident-to-resident abuse, occurring between 11/10/21 and 04/21/23, were reviewed. Each lacked evidence of a thorough investigation, witness statements, resident interviews, and identification of causal factors to implement interventions to prevent further resident to resident altercations/abuse. 1. The 05/22/22 Resident to Resident Facility Self-Investigation documented on 05/21/22 R170 and R9 were roommates, and they hit each other with a grabber. R9 went to R170's side of the room, with a grabber in his hand and hit his roommate in the head. R170 grabbed the grabber and hit R9 back. R170 went to the emergency room for sutures to his head. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 05/22/22 Progress Note documented on 05/21/22 at 11:30 PM the nurse entered the room and R9 sat on the floor yelling at R170, that he needed to move out of his house. R9 made several attempts to crawl towards R170. The staff moved R9 to a different room and R9 denied pain upon assessment. R170's 05/22/22 Progress Note documented R170 went via ambulance to the emergency room and returned at 03:01 AM with nine sutures to the laceration on his head. 2. The 01/10/23 Resident to Resident Facility Self-Investigation documented on 01/09/23 R25 propelled her electric wheelchair over R18's foot causing fractures of two phalanges (digital bones in the feet) of his right foot. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R25 lacked documentation of the incident on 01/09/23. R18's 01/09/23 Progress Note documented the nurse heard screaming in the foyer. When the nurse arrived, staff stated R25 ran over R18's right foot with her mechanical chair. The nurse documented swelling and bleeding to R18's right big toe. Pressure and ice were applied and R18 complained of pain and staff administered an analgesic. The staff received an order for an X-ray of R18's foot/toes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R18's 01/09/23 Progress Note documented results of the x-ray revealed possible minimally displaced fractures involving the middle phalanges of the second and third toes. The staff received an order from the provider for R18 to be non-weight bearing on the right foot and to keep the toes immobilized. 3. The 11/10/21 Resident to Resident Facility Self- Investigation documented on 11/10/21, R2 was walking down the hall and put his leg out to trip R171. The investigation lacked resident interviews, identification of causal factors, and witness statements. Review of the investigation dated 11/10/21 documented an incomplete investigation with no interventions to protect residents and prevent the abuse from recurring. The 11/10/21 Progress Note documented staff were in hall two, talking, when they heard R171 state that R2 had kicked her. R2 stated I just wanted to trip her to staff. R2 continued to walk down the hall and into his room. 4. The Resident to Resident Facility Self-Investigation dated 12/13/21 documented on 12/07/21 R172 was following R178 and R178 turned and hit R172. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 12/07/21 Progress Note documented staff reported R172 followed R178 and at one-point R172 hit R178 and then R178 punched R172 in the neck. The staff redirected R178 without incident. 5. The Resident to Resident Facility Self- Investigation dated 05/03/22 reported R178 punched R175 in the dining room area when the resident stood up from the table. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note dated 05/01/22 documented R178 punched R175 in the dining room area when the resident stood up from the table. At 05:28 PM staff were monitoring R178 for Risperdal (antipsychotic) and discontinued Buspar (antianxiety) and Trazadone (antidepressant) medications. The progress note revealed R178 hit another resident in the head. 6. The Resident to Resident Facility Self- Investigation dated 02/16/23 reported R178 pinned R21 to the wall and punched her in the chest. R21 in turn scratched R178 right hand. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 02/16/23 Progress Note documented an unidentified Certified Nurse Aide on hall four, reported to the Licensed Nurse, she saw R178 pin a female resident to the wall in the hallway. R21 screamed at R178 telling him to stop. R178 then punched R21 in the chest and she in return scratched his hand. The nurse went to hall four to assess what happened. Scratches and bleeding were noted to R178's right hand. 7. The 05/02/22 Resident to Resident Facility Self-Investigation documented on 05/01/22, R173 grabbed R174's arms and shook her hard. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 05/01/22 Progress Note for R173 documented R173 grabbed another resident and shook her violently. The Progress Note documented an incident of R173 punched another resident the day before this incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility did not report the prior day incident mentioned in the 05/01/22 Progress Note to the state Agency as required 8. The Resident to Resident Facility Self-Investigation dated 06/14/22 documented on 06/14/22, R4 struck R176, then R176 struck R4. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 06/14/22 Progress Note documented R4 and R176 argued, and the staff attempted to intervene, but the residents struck one another. Documentation lacked determination or declaration of who struck first. R4 and R176 were assessed for injuries and escorted to their respective rooms without further incident. 9. On 08/01/22 the Resident to Resident Facility Self-Investigation dated 08/02/22, documented R4 struck R34, again. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 08/02/22 Progress Note documented R4 punched another resident in the face. The residents were removed to a safe environment and assessed them, with no injuries found on either resident. The facility sent R4 via EMS to the Behavioral Health Unit (BHU) for evaluation related to his behavior. The EHR lacked additional information. 10. The 09/01/22 Resident to Resident Facility Self-Investigation documented on 08/30/22, R4 struck R51. The investigation revealed R4 thought R51 called him a bad name, so R4 struck R51. The EHR lacked documentation related to this incident. The investigation lacked resident interviews, identification of causal factors, and witness statements. 11. The 12/08/22 Resident to Resident Facility Self-Investigation documented on 12/08/22 R31 pushed R21 causing her to fall. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 12/08/22. 12. The 01/02/23 Resident to Resident Facility Self-Investigation documented on 01/02/23 R31 pushed R177. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 01/02/23. 13. The 02/15/23 Resident to Resident Facility Self-Investigation documented on 02/15/23 R57's spouse reported R57 had a bruise. Through investigation of video recordings, it was determined R31 entered R57's. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 02/15/23. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	14. The Resident to Resident Facility Self-Investigation dated 04/21/23 documented on 04/21/23 R21 entered R57's room and allegedly assaulted R57 which resulted in minor injuries to R57 which required bandages. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Notes lacked documentation of the incident on 04/21/23. On 05/01/23 at 10:00 AM Administrative Staff A reported she did not interview the other residents because the residents were confused, and most of the incidents occurred on the unit, and it would not do any good. She relied on the nursing staff to monitor for further behaviors and completed notifications. She did not know she had to complete a full investigation on a facility reported event . The facility's 03/03/22 Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, documented residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, or other individuals. The policy documented all allegations of abuse should be reported to the administrator immediately. Additionally, the policy documented all allegations of abuse shall be reported to the appropriate state agency no later than two hours after the allegation was made and allegations that result from a crime must be reported to law enforcement no later than 24 hours after the incident. The policy included the administrator would complete documentation of the allegation as follows: 1. Review documentation in EHR (including assessment if allegation resulted in injury) 2. Assess resident for injury if allegation involves physical abuse. 3. Provide notifications to primary care provider and responsible party. 4. Attempt to obtain witness statements from all known witnesses. 5. Preserve physical evidence (if applicable). The policy documented the facility shall implement measures to prevent further potential abuse from occurring. Due to the number of resident-to-resident altercations and lack of thorough investigations and preventative measures to protect residents from abuse, placed the residents in immediate jeopardy. On 04/27/23 at 02:45 PM, Administrative Staff A was informed of the immediate jeopardy status and provided the Immediate Jeopardy Template for failure to provide a safe environment free from abuse. The facility failed to ensure residents were free from resident-to-resident abuse from 11/10/21 through 04/21/23, involving 19 residents. After each abuse incident, the facility did not implement any interventions to prevent further abuse. This had the potential to affect all 70 residents. The facility provided an acceptable plan for removal of the IJ on 04/27/23 at 06:00 PM which included the following: 1. All staff educated on abuse policy, forms of abuse, and the steps for reporting alleged abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The surveyor verified the implementation of the corrective actions onsite on 05/02/23 and the deficient practice remained at an G scope and severity.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46960 The facility reported a census of 70 residents. The review included 14 facility reported incidents with allegations of resident-to-resident abuse, between the dates of 11/10/21 and 04/21/23. Based on observation, interview, and record review, the facility failed to provide a safe and secure living environment for the residents of the facility with the failure to report the incidents in a timely manner as required, following 11 of these 14 incidents reviewed. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. Findings included: - During the onsite health resurvey, the following 14 facility reported incidents regarding allegations of resident-to-resident abuse, occurring between 11/10/21 and 04/21/23, were reviewed. Each lacked evidence of a thorough investigation, witness statements, resident interviews, and identification of causal factors to implement interventions to prevent further resident to resident altercations/abuse. 1. The 05/22/22 Resident to Resident Facility Self-Investigation documented on 05/21/22 R170 and R9 were roommates, and they hit each other with a grabber. R9 went to R170's side of the room, with a grabber in his hand and hit his roommate in the head. R170 grabbed the grabber and hit R9 back. R170 went to the emergency room for sutures to his head. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 05/22/22 Progress Note documented on 05/21/22 at 11:30 PM the nurse entered the room and R9 sat on the floor yelling at R170, that he needed to move out of his house. R9 made several attempts to crawl towards R170. The staff moved R9 to a different room and R9 denied pain upon assessment. R170's 05/22/22 Progress Note documented R170 went via ambulance to the emergency room and returned at 03:01 AM with nine sutures to the laceration on his head. The facility reported the incident to the State Agency (SA) on 05/24/22, three days after the incident. 2. The 01/10/23 Resident to Resident Facility Self-Investigation documented on 01/09/23 R25 propelled her electric wheelchair over R18's foot causing fractures of two phalanges (digital bones in the feet) of his right foot. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R25 lacked documentation of the incident on 01/09/23. R18's 01/09/23 Progress Note documented the nurse heard screaming in the foyer. When the nurse arrived, staff stated R25 ran over R18's right foot with her mechanical chair. The nurse documented swelling and bleeding to R18's right big toe. Pressure and ice were applied and R18 complained of pain and staff administered an analgesic. The staff received an order for an X-ray of R18's foot/toes. (continued on next page)

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	175078	A. Building B. Wing	05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R18's 01/09/23 Progress Note documented results of the x-ray revealed possible minimally displaced fractures involving the middle phalanges of the second and third toes. The staff received an order from the provider for R18 to be non-weight bearing on the right foot and to keep the toes immobilized. The facility reported the incident to the SA on 01/10/23, one day after the event occurred. 3. The 11/10/21 Resident to Resident Facility Self- Investigation documented on 11/10/21, R2 was walking down the hall and put his leg out to trip R171. The investigation lacked resident interviews, identification of causal factors, and witness statements. Review of the investigation dated 11/10/21 documented an incomplete investigation with no interventions to protect residents and prevent the abuse from recurring. The 11/10/21 Progress Note documented staff were in hall two, talking, when they heard R171 state that R2 had kicked her. R2 stated I just wanted to trip her to staff. R2 continued to walk down the hall and into his room. The facility reported the incident to the SA on 11/12/21 at 11:26 AM, two days after the incident. 4. The Resident to Resident Facility Self-Investigation dated 12/13/21 documented on 12/07/21 R172 was following R178 and R178 turned and hit R172. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 12/07/21 Progress Note documented staff reported R172 followed R178 and at one-point R172 hit R178 and then R178 punched R172 in the neck. The staff redirected R178 without incident. The facility reported the incident to the SA on 12/13/21 at 02:28 PM, six days after the incident. 5. The Resident to Resident Facility Self- Investigation dated 05/03/22 reported R178 punched R175 in the dining room area when the resident stood up from the table. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note dated 05/01/22 documented R178 punched R175 in the dining room area when the resident stood up from the table. At 05:28 PM staff were monitoring R178 for Risperdal (antipsychotic) and discontinued Buspar (antianxiety) and Trazadone (antidepressant) medications. The progress note revealed R178 hit another resident in the head. The facility reported the incident to the SA on 05/03/22 at 08:32 AM, two days after the incident. 6. The Resident to Resident Facility Self- Investigation dated 02/16/23 reported R178 pinned R21 to the wall and punched her in the chest. R21 in turn scratched R178 right hand. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 02/16/23 Progress Note documented an unidentified Certified Nurse Aide on hall four, reported to the Licensed Nurse, she saw R178 pin a female resident to the wall in the hallway. R21 screamed at R178 telling him to stop. R178 then punched R21 in the chest and she in return scratched his hand. The nurse went to hall four to assess what happened. Scratches and bleeding were noted to R178's right hand. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility reported the incident to the SA on 02/17/23, one day after the incident. 7. The 05/02/22 Resident to Resident Facility Self-Investigation documented on 05/01/22, R173 grabbed R174's arms and shook her hard. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 05/01/22 Progress Note for R173 documented R173 grabbed another resident and shook her violently. The Progress Note documented an incident of R173 punched another resident the day before this incident. The facility did not report the prior day incident mentioned in the 05/01/22 Progress Note to the state Agency as required The facility reported the incident to the SA on 05/03/22, two days after the incident. 8. On 08/01/22 the Resident to Resident Facility Self-Investigation dated 08/02/22, documented R4 struck R34, again. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 08/02/22 Progress Note documented R4 punched another resident in the face. The residents were removed to a safe environment and assessed them, with no injuries found on either resident. The facility sent R4 via EMS to the Behavioral Health Unit (BHU) for evaluation related to his behavior. The EHR lacked additional information. The incident was reported to the SA on 08/02/22, one day after the incident. 9. The 09/01/22 Resident to Resident Facility Self-Investigation documented on 08/30/22, R4 struck R51. The investigation revealed R4 thought R51 called him a bad name, so R4 struck R51. The EHR lacked documentation related to this incident. The investigation lacked resident interviews, identification of causal factors, and witness statements. The incident was reported to the SA on 08/30/22 at 08:29 PM one day before the incident was dated. 10. The 12/08/22 Resident to Resident Facility Self-Investigation documented on 12/08/22 R31 pushed R21 causing her to fall. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 12/08/22. The facility reported the incident to the SA on 12/14/22, six days after the incident. 11. The 01/02/23 Resident to Resident Facility Self-Investigation documented on 01/02/23 R31 pushed R177. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 01/02/23. The facility reported the incident to the SA on 01/03/23, one day after the incident. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 05/01/23 at 10:00 AM Administrative Staff A reported she did not interview the other residents because the residents were confused, and most of the incidents occurred on the unit, and it would not do any good. She relied on the nursing staff to monitor for further behaviors and completed notifications. She did not know she had to complete a full investigation on a facility reported event. The facility's 03/03/22 Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, documented residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, or other individuals. The policy documented all allegations of abuse should be reported to the administrator immediately. Additionally, the policy documented all allegations of abuse shall be reported to the appropriate state agency no later than two hours after the allegation was made and allegations that result from a crime must be reported to law enforcement no later than 24 hours after the incident. The policy included the administrator would complete documentation of the allegation as follows: 1. Review documentation in EHR (including assessment if allegation resulted in injury) 2. Assess resident for injury if allegation involves physical abuse. 3. Provide notifications to primary care provider and responsible party. 4. Attempt to obtain witness statements from all known witnesses. 5. Preserve physical evidence (if applicable). The policy documented the facility shall implement measures to prevent further potential abuse from occurring. Due to the number of resident-to-resident altercations and lack of timely reporting of incidents, this placed the residents in immediate jeopardy. On 04/27/23 at 02:45 PM, Administrative Staff A was informed of the immediate jeopardy status and provided the Immediate Jeopardy Template for failure to provide a safe environment free from abuse. The facility failed to ensure residents were free from resident-to-resident abuse from 11/10/21 through 04/21/23, involving 19 residents. After each abuse incident, the facility did not report the incidents in a timely manner to the SA as required. This had the potential to affect all 70 residents. The facility provided an acceptable plan for removal of the IJ on 04/27/23 at 06:00 PM which included the following: 1. All staff educated on abuse policy, forms of abuse, and the steps for reporting alleged abuse. The surveyor verified the implementation of the corrective actions onsite on 05/02/23 and the deficient practice remained at a F scope and severity.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. 46960 The facility reported a census of 70 residents. The review included 14 facility self-reported incidents with allegations of resident-to-resident abuse, between the dates of 11/10/21 and 04/21/23. Based on observation, interview, and record review the facility failed to conduct a thorough investigation of the allegations of resident-to-resident abuse and failed to take appropriate corrective actions to protect residents from further abuse. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. Findings included: - During the onsite health resurvey, the following 14 facility reported incidents regarding allegations of resident-to-resident abuse, occurring between 11/10/21 and 04/21/23, were reviewed. Each lacked evidence of a thorough investigation, witness statements, resident interviews, and identification of causal factors to implement interventions to prevent further resident to resident altercations/abuse. 1. The 05/22/22 Resident to Resident Facility Self-Investigation documented on 05/21/22 R170 and R9 were roommates, and they hit each other with a grabber. R9 went to R170's side of the room, with a grabber in his hand and hit his roommate in the head. R170 grabbed the grabber and hit R9 back. R170 went to the emergency room for sutures to his head. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 05/22/22 Progress Note documented on 05/21/22 at 11:30 PM the nurse entered the room and R9 sat on the floor yelling at R170, that he needed to move out of his house. R9 made several attempts to crawl towards R170. The staff moved R9 to a different room and R9 denied pain upon assessment. R170's 05/22/22 Progress Note documented R170 went via ambulance to the emergency room and returned at 03:01 AM with nine sutures to the laceration on his head. 2. The 01/10/23 Resident to Resident Facility Self-Investigation documented on 01/09/23 R25 propelled her electric wheelchair over R18's foot causing fractures of two phalanges (digital bones in the feet) of his right foot. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R25 lacked documentation of the incident on 01/09/23. R18's 01/09/23 Progress Note documented the nurse heard screaming in the foyer. When the nurse arrived, staff stated R25 ran over R18's right foot with her mechanical chair. The nurse documented swelling and bleeding to R18's right big toe. Pressure and ice were applied and R18 complained of pain and staff administered an analgesic. The staff received an order for an xray of R18's foot/toes. R18's 01/09/23 Progress Note documented results of the x-ray revealed possible minimally displaced fractures involving the middle phalanges of the second and third toes. The staff received an order from the provider for R18 to be non-weight bearing on the right foot and to keep the toes immobilized. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. The 11/10/21 Resident to Resident Facility Self- Investigation documented on 11/10/21, R2 was walking down the hall and put his leg out to trip R171. The investigation lacked resident interviews, identification of causal factors, and witness statements. Review of the investigation dated 11/10/21 documented an incomplete investigation with no interventions to protect residents and prevent the abuse from recurring. The 11/10/21 Progress Note documented staff were in hall two, talking, when they heard R171 state that R2 had kicked her. R2 stated I just wanted to trip her to staff. R2 continued to walk down the hall and into his room. 4. The Resident to Resident Facility Self-Investigation dated 12/13/21 documented on 12/07/21 R172 was following R178 and R178 turned and hit R172. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 12/07/21 Progress Note documented staff reported R172 followed R178 and at one-point R172 hit R178 and then R178 punched R172 in the neck. The staff redirected R178 without incident. 5. The Resident to Resident Facility Self- Investigation dated 05/03/22 reported R178 punched R175 in the dining room area when the resident stood up from the table. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note dated 05/01/22 documented R178 punched R175 in the dining room area when the resident stood up from the table. At 05:28 PM staff were monitoring R178 for Risperdal (antipsychotic) and discontinued Buspar (antianxiety) and Trazadone (antidepressant) medications. The progress note revealed R178 hit another resident in the head. 6. The Resident to Resident Facility Self- Investigation dated 02/16/23 reported R178 pinned R21 to the wall and punched her in the chest. R21 in turn scratched R178 right hand. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 02/16/23 Progress Note documented an unidentified Certified Nurse Aide on hall four, reported to the Licensed Nurse, she saw R178 pin a female resident to the wall in the hallway. R21 screamed at R178 telling him to stop. R178 then punched R21 in the chest and she in return scratched his hand. The nurse went to hall four to assess what happened. Scratches and bleeding were noted to R178's right hand. 7. The 05/02/22 Resident to Resident Facility Self-Investigation documented on 05/01/22, R173 grabbed R174's arms and shook her hard. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 05/01/22 Progress Note for R173 documented R173 grabbed another resident and shook her violently. The Progress Note documented an incident of R173 punched another resident the day before this incident. The facility did not report the prior day incident mentioned in the 05/01/22 progress note to the state Agency as required. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. The Resident to Resident Facility Self-Investigation dated 06/14/22 documented on 06/14/22, R4 struck R176, then R176 struck R4. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 06/14/22 Progress Note documented R4 and R176 argued, and the staff attempted to intervene, but the residents struck one another. Documentation lacked determination or declaration of who struck first. R4 and R176 were assessed for injuries and escorted to their respective rooms without further incident. 9. On 08/01/22 the Resident to Resident Facility Self-Investigation dated 08/02/22, documented R4 struck R34, again. The investigation lacked resident interviews, identification of causal factors, and witness statements. The 08/02/22 Progress Note documented R4 punched another resident in the face. The residents were removed to a safe environment and assessed them, with no injuries found on either resident. The facility sent R4 via EMS to the Behavioral Health Unit (BHU) for evaluation related to his behavior. The EHR lacked additional information. 10. The 09/01/22 Resident to Resident Facility Self-Investigation documented on 08/30/22, R4 struck R51. The investigation revealed R4 thought R51 called him a bad name, so R4 struck R51. The EHR lacked documentation related to this incident. The investigation lacked resident interviews, identification of causal factors, and witness statements. 11. The 12/08/22 Resident to Resident Facility Self-Investigation documented on 12/08/22 R31 pushed R21 causing her to fall. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 12/08/22. 12. The 01/02/23 Resident to Resident Facility Self-Investigation documented on 01/02/23 R31 pushed R177. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 01/02/23. 13. The 02/15/23 Resident to Resident Facility Self-Investigation documented on 02/15/23 R57's spouse reported R57 had a bruise. Through investigation of video recordings, it was determined R31 entered R57's. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 02/15/23. 14. The Resident to Resident Facility Self-Investigation dated 04/21/23 documented on 04/21/23 R21 entered R57's room and allegedly assaulted R57 which resulted in minor injuries to R57 which required bandages. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Notes lacked documentation of the incident on 04/21/23. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 05/01/23 at 10:00 AM Administrative Staff A reported she did not interview the other residents because the residents were confused, and most of the incidents occurred on the unit, and it would not do any good. She relied on the nursing staff to monitor for further behaviors and completed notifications. She did not know she had to complete a full investigation on a facility reported event. The facility's 03/03/22 Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, documented residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, or other individuals. The policy documented all allegations of abuse should be reported to the administrator immediately. Additionally, the policy documented all allegations of abuse shall be reported to the appropriate state agency no later than two hours after the allegation was made and allegations that result from a crime must be reported to law enforcement no later than 24 hours after the incident. The policy included the administrator would complete documentation of the allegation as follows: 1. Review documentation in EHR (including assessment if allegation resulted in injury) 2. Assess resident for injury if allegation involves physical abuse. 3. Provide notifications to primary care provider and responsible party. 4. Attempt to obtain witness statements from all known witnesses. 5. Preserve physical evidence (if applicable). The policy documented the facility shall implement measures to prevent further potential abuse from occurring. Due to the number of resident-to-resident altercations and lack of thorough investigations and preventative measures to protect residents from abuse, placed the residents in immediate jeopardy. On 04/27/23 at 02:45 PM, Administrative Staff A was informed of the immediate jeopardy status and provided the Immediate Jeopardy Template for failure to provide a safe environment free from abuse. The facility failed to ensure residents were free from resident-to-resident abuse from 11/10/21 through 04/21/23, involving 19 residents. The facility failed to conduct a thorough investigation of the allegations of resident-to-resident abuse and failed to take appropriate corrective actions to protect residents from further abuse. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. The facility provided an acceptable plan for removal of the IJ on 04/27/23 at 06:00 PM which included the following: 1. All staff educated on abuse policy, forms of abuse, and the steps for reporting alleged abuse. The surveyor verified the implementation of the corrective actions onsite on 05/02/23 and the deficient practice remained at an F scope and severity.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 41302 The facility reported a census of 70 residents, with 18 included in the sample. Based on observation, interview, and record review the facility failed to incorporate the recommendations from a Preadmission Screening and Resident Review (PASRR) level II evaluation report into Resident (R) 12's assessment, care plan, and/or a transition of care. Findings Included: - The Electronic Health Record (EHR) for R12 revealed the following diagnoses; anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), mild cognitive impairment (characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, getting along in social situations and school activities), and schizoaffective disorder (mental health disorder characterized by a combination of symptoms of schizophrenia). The 01/17/20 Preadmission Screening and Resident Review (PASRR) Determination Letter informed R12 that the facility would provide and maintain consistent implementation across settings of programs designed to teach him the daily living skills he would need, noted that R12 would benefit from a locked unit, and further noted the nursing facility should develop a care plan to ensure the resident are functioned at their highest practicable level. The 03/23/23 Care Plan documented that R12 required a calm approach to avoid startling him. The care plan directed staff to monitor R12's behaviors and to provide treatments and medications as ordered. The care plan lacked documentation regarding a locked or secured unit. Observation on 04/25/23 at 01:04 PM revealed R12 lying in bed covered with a blanket and the head of the bed elevated. R12 was clean and able to make his needs known. On 04/25/23 at 01:04 PM Licensed Nurse X stated R12 took nothing by mouth, continued to smoke, and was able to make his needs known. She stated she did not think R12 would benefit from the memory unit. She confirmed she had nothing to do with the placement of the residents. On 04/27/23 at 02:15 PM Social Services (SS) U stated according to the Level II PASRR report the facility should have placed R12 in the memory unit, she stated she did not believe R12 would benefit from the unit, but confirmed they had not obtained a new assessment. On 04/27/23 at 03:33 PM Administrative Nurse B revealed she did not know that the Level II PASRR determination letter for R12 recommended the memory unit. Administrative Nurse B confirmed she expected her staff to follow the recommendations of the letter. The facility's March 2019 Behavioral Assessment, Intervention, and Monitoring policy directed staff the Level II (evaluation and determination) report would be used when conduction the resident assessment and developing the care plan. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to incorporate the recommendations from the PASARR level II evaluation report into R12's assessment, care plan, or transition of care, or to obtain a new assessment following a significant change in condition.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 41302 The facility reported a census of 70 residents with 18 sampled, including one for PASRR (Pre-Admission Screening and Resident Review). Based on interview and record review the facility failed to inform the state mental health authority in a timely manner of Resident (R) 12's significant change on 10/14/22. Findings included: - Review of R12's medical record from October 2022 through April 2023 lacked notification to the state mental health authority regarding R12's significant change of 10/14/22, which included the placement of a feeding tube, and the increased need for assistance with activities of daily living. Review of the PASRR Determination Letter for R12 dated 01/17/22, indicated the resident had appropriate diagnoses to require a level II evaluation. On 04/27/23 at 02:15 PM Social Services Staff U stated she did not know she needed to inform anyone when resident's requiring a PASRR had a change in condition. On 04/27/23 at 03:33 PM Administrative Nurse B revealed she did not know how to answer the question. She confirmed the significant change had not been reported as required. The facility's March 2019 Behavioral Assessment, Intervention, and Monitoring policy directed staff the Level II (evaluation and determination) report would be used when conduction the resident assessment and developing the care plan. The current Level II residents would be referred for an additional PASARR (PASSR) level II evaluation upon a significant change in status assessment. The facility failed to notify the state mental health authority promptly after R12's significant change on 10/24/22.

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	175078	A. Building B. Wing	05/02/2023

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Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility reported a census of 70 residents with 18 residents included in the sample. Based on observation, interview, and record review the facility failed to develop a comprehensive care plan for one resident of 18 residents reviewed for care plans. Resident (R) 216. Findings included: - Resident 216's physician orders dated 04/05/23 revealed the following diagnoses: fractured right fibula (broken bone), chronic obstructive pulmonary disease (COPD) - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), megaloblastic anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues). The Minimum Data Set (MDS) entry tracking documented the resident admitted to the facility on [DATE]. The five-day admission MDS, dated [DATE], revealed the resident had a brief interview for mental status (BIMS) of 15 indicating intact cognition. The resident required extensive assistance for transfers and toileting and was non ambulatory. The resident required supervision and assistance of one while in the wheelchair. The resident received as needed pain medications. The resident had a fall with fracture prior to admission. The resident received anti depression, anticoagulant, diuretic, and opioid pain medication daily during the 7-day observation period. The resident received Physical Therapy (PT) and Occupational therapy (OT) for rehabilitation of fractured fibula. The Care Area Assessment (CAA) dated 04/09/23 revealed the resident triggered for 11 out of the 20 areas. The communication CAA documented the resident required hearing aides due to hearing loss. The Activities of daily living (ADL) CAA documented the resident required extensive assistance with bed mobility, transfers, and toileting. The resident was dependent with bathing, required limited assistance with personal hygiene and supervision with locomotion off and on the unit. The resident was weight bearing as tolerated (WBAT) on the left lower extremity and non-weight bearing (NWB) on her right lower extremities (RLE). The resident required a wheelchair for mobility. The Urinary incontinence and indwelling catheter CAA documented staff assist her, and she was able to let staff know when she required changing. The resident required a diuretic (medication to promote the formation and excretion of urine) that increased her risk for urinary incontinence. The Psychosocial Well-Being CAA and the Activities CAA documented the resident would visit with staff and other residents, attended smoke breaks as scheduled, watched television and did word search puzzles. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Falls CAA documented the resident was at an increased risk for falls related to pain medication, psychotropic medications (medications capable of affecting the mind, emotions, and behavior), and history of falls with fractures. The Dental Care CAA documented the resident had dentures but were left at her home. The Pressure Ulcer/ Injury CAA documented the resident was at risk for development of pressure ulcers due to incontinence and decreased mobility. The Psychotropic Drug Use CAA documented the resident received an antidepressant medication daily and required monitoring for behaviors and adverse side effects. The Pain CAA documented the resident had pain with movement. The Return to Community Referral CAA documented the resident would like to return back to her apartment after her facility stay. Record review on 04/25/23 revealed the facility failed to develop a comprehensive care plan for this resident 14 days as required after the completion of the admission MDS (04/09/23). On 04/25/23 at 10:00 AM, observation revealed the resident left the dining room after she ate her breakfast self-propelling herself in her wheelchair. On 05/01/23 at 08:30 AM revealed the resident sat on her bed and was dressed in her night clothes. The resident was extremely agitated and had been yelling for someone to help her. Interview on 04/25/23 at 10:05 AM, the resident reported she ate a late breakfast because to her it was more important to go outside to smoke in the morning when she got up. She was here to get patched up and then planned to go back home. On 05/01/23 at 04:35 PM, Administrative Nurse B verified she was aware the resident's care plan had not been developed. The Director of Nurses quit a couple of weeks prior and she had been assisting with that duty to help out as well. Review of the facility policy named Care Plans, Comprehensive Person-Centered dated 12/16 revealed the comprehensive care plan is to be developed within seven days of the completion of the required comprehensive assessment (MDS) The facility failed to develop a comprehensive plan of care for this resident to ensure staff provided cares as needed to maintain optimal function for this resident.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility census totaled 70 residents with 18 included in the sample. Based on observation, interview, and record review the facility failed to provide timely care to skilled Resident (R) 216, who was in rehabilitation, with plans to return home. Findings included: - Resident 216's physician orders dated 04/05/23 revealed the following diagnoses: fractured (broken bone) right fibula (lower leg bone), chronic obstructive pulmonary disease (COPD, progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and megaloblastic anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues). The Five-day Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) of 15, indicating intact cognition. The resident required extensive assistance for transfers and toileting and was non-ambulatory. The resident required supervision and assistance of one staff while in the wheelchair. The resident received as needed pain medications. The resident had a fall with fracture prior to admission. The resident received antidepression, anticoagulant, diuretic, and opioid pain medication daily during the seven-day observation period. The resident received Physical Therapy (PT) and Occupational therapy (OT) for rehabilitation of a fractured fibula. The 04/09/23 Activities of Daily Living (ADL) Care Area Assessment (CAA) revealed R168 required extensive assistance of one staff with bed mobility, transfers, and toileting; required limited assistance with personal hygiene, and supervision with locomotion off and on the unit. The resident was weight bearing as tolerated (WBAT) on the left lower extremity and non-weight bearing (NWB) on right lower extremities (RLE). R168 used a wheelchair for mobility. The resident was alert and oriented, and could make her needs and wants known. Review of the resident's Electronic Medical Record (EMR) revealed no completed care plan in the record. The 04/05/23 at 09:31 PM Nursing Note revealed the resident admitted today from a local hospital, transported via facility van, and arrived around 04:15 PM, and was wheelchair bound. She was alert and oriented and could verbalize her needs. The resident presented with an open reduction internal fixation (ORIF) of the right Tibia (lower leg bone), and right fracture of the patella (kneecap). She was to receive skilled rehabilitation and was non-weight bearing on the right leg, partial weight bearing on the left leg, and she required PT/OT, activities. The staff were to keep the call light at a reachable position, the resident could tolerate when transferred to bed, and the resident was in bed at the time. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/23 at 08:15 AM revealed the resident sat in bed in her night clothes. The resident was agitated and yelled for someone to help her get up and out of bed. The resident had been yelling for quite some time Approx 30 minutes. On 05/01/23 at 09:30 AM observation revealed the resident yelled for help. When the surveyor entered R216's room, she stated she had been waiting with her call light on for two hours for someone to help her get up for the day. Said she had her call light on the whole time. On 05/01/23 at 09:40 AM surveyor went to the nurses' station on 100 hall and asked if there were any Certified Nurse Aides (CNA) on the 500 hall. Administrative Staff A reported the CNA on the 200 hall was to care for the 500 hall, too. The surveyor informed her R216 reported her call light being on for two hours. The call light board showed R216's light on and had re-paged 12 times (each re-page is three minutes long; for a total of over 35 minutes) as the resident waited for help. Administrative Staff A stated the office people were helping on the floor and names were added to the schedule day sheet including Activities Staff M. The surveyor asked Activities Staff M, but she informed the surveyor she was not working the floor, she was in activities. Activities Staff M and Administrative Staff A walked with the surveyor to R216's room and found a therapy staff member with the resident, who had been hollering, so she helped the resident get up. Interview on 05/01/23 at 10:30 AM R216 reported she was here for rehabilitation and wanted to go home as soon as she could, but it was not helping her laying in this bed forever waiting on help to get up. She said she was trying to build her strength but could not if they were not going to help her. She said could do a lot for herself but with her fracture, she was limited. Interview on 04/26/23 at 03:44 PM revealed Certified Nurse Aide (CNA) K reported the resident had kind of come and went. She would come in and rehabilitate then go home for a while then she was back. She said the resident was no trouble and did not complain. On 05/01/23 at 04:35 PM Administrative Nurse B reported she knew of the problem with the call lights and when the resident hollered about not getting assistance, she went to the 400 hall and asked a CNA to go help the resident. On 05/01/23 at 09:00 AM Administrative Staff A reported the staffing for the 200-500 hall was one CNA and the CMA after she passed her medications. Residents had call lights to call for assistance and the CNA would have to come to the 100-hall office to see which lights were on. Administrative Staff A reported they were using the department heads to fill in this morning and began writing names of department heads on the day sheet. Review of the facility policy Activities of Daily Living (ADLs) Supporting dated 2018 revealed the facility would provide the residents with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The facility failed to provide timely care to skilled resident R216, who required rehabilitation and had plans to return home.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41302 The facility census totaled 70 residents, with 18 in the sample, including one resident reviewed for accident hazards. Based on observation, interview, and record review the facility failed to ensure staff provided adequate supervision and followed the resident's fall prevention interventions to prevent further falls for Resident (R) 18, including one fall which resulted in a fractured (broken bone) right femur (thigh bone) and surgical repair. Findings included: - R18's diagnoses from the Electronic Health Record (EHR) documented anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder), and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The 07/19/22 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R18 required extensive assistance of one staff for bed mobility, dressing, and personal hygiene, and extensive assistance of two staff for transfers. R18 had no falls since the prior assessment. The 02/23/23 Quarterly MDS documented a BIMS of 15, indicating intact cognition. R18 required extensive assistance of two staff for all activities of daily living. The MDS further noted R18 had no falls since the prior assessment. R18 required surgery to repair a fracture to the pelvis, hip, leg, or ankle. The 01/25/23 Care Plan documented R18 was at risk for falls. The Care Plan directed staff to follow facility fall protocol. The Care Plan directed staff to use a body pillow for positioning and mattress perimeters for R18 as of 09/19/22. The Care Plan lacked an intervention for the fall on 12/25/22. Review of the Fall Investigation dated 12/25/22, documented at 01:41 PM, R18 turned on his call light and the responding CNA entered the room, then left the room to gather linens to change R18's bed. While the CNA was out of the room, R18 rolled off the bed, which resulted in a fracture to his right femur. The investigation noted the bed was not at an appropriate height. The investigation lacked witness statements, identification of causal factors, and resident interviews. Review of Progress Note dated 12/25/22, documented a CNA reported to the nurse he had been in the room changing R18's linens, he stepped out of the room to get linens, and R18 rolled out of the bed while he was outside of the room. R18 had a laceration to the right side of his head and a skin tear to his right hand. R18 complained of pain to his right hip. The staff obtained his vital signs and the nurse cleaned the wounds and did not move R18 until emergency service (EMS) staff arrived to assess R18. EMS staff and a Licensed Nurse lifted R18 from the floor to a stretcher. R18 complained of pain to his right leg. R18 transferred via ambulance to the hospital for further evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Progress Note dated 12/27/22, documented R18 returned from the hospital around 03:00 PM, via gurney, transported by an outside transportation services. R18 had a suprapubic (a urinary catheter that is inserted through a small incision in the lower abdomen) catheter in place. R18 had confusion and his speech was not clearly understood. R18 had an incision to his right hip due to a surgical procedure. R18 had a dressing covering the incision with an order to leave the dressing in place until his follow up appointment, and the staff were to apply ice intermittently to his right hip for discomfort, as needed. The staff were to use a mechanical lift for transfers of R18, with the assistance of two staff. Review of the Fall Scene Investigation Questionnaire dated 12/25/22, documented the CNA had answered the questions of toileting time and noted a urinary catheter in place, R18 was incontinent at the time of fall, had no footwear in place, noted the last time R18 had eaten was at lunch, noted R18 was changed at 01:45 PM, and seen at lunch, at noon. Furthermore, the CNA documented R18's call light was on, R18 told him nothing, and the fall happened because R18 rolled to the floor. On 04/26/23 at 03:25 PM, observed R18 lying in his bed, in the regular height position, with no mattress perimeters or body pillow in place. He rested with his eyes closed and awoke at the calling of his name. On 04/26/23 at 03:25 PM, R18 reported on the morning of 12/25/22, he had just woke up and rolled over, right onto the floor. R18 stated he did not think anyone was trying to hurt him. On 05/01/23 at 08:36 AM, Certified Nurse Aide (CNA) D reported in the event of an incident or altercation, staff should report to the nurse immediately and stated several fall interventions that the facility used. She did not know of any fall interventions needed for R18. On 04/27/23 at 04:40 AM, Licensed Nurse (LN) N reported with a fall, she assessed the resident, provide any first aid needed, call for EMS if needed, make a thorough progress note, and notify management, provider, and family. LN N reported the nurse was responsible for putting an intervention in place to prevent further falls. On 04/27/23 at 10:30 AM, Administrative Staff A revealed she expected staff to notify her immediately of incidents. She confirmed the nurse should make a complete progress note to include the entirety of the incident and any interventions put into place. Administrative Staff A confirmed no witness statements, identification of causal factors, or resident interviews were completed for R18's 12/25/22 fall which resulted in a fracture. The facilities 12/23/21 Fall Prevention Program policy documented falls could result in injury and the very least, emotional trauma. The facility role was to assure they identified the residents at risk for falls and assure the facility had individualized preventive approaches in place to assist with the prevention of future falls. The facility failed to provide adequate supervision and assistive devices to prevent accidents, when R18 fell out of bed on 12/25/22, which resulted in a right femur fracture and required surgical repair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Environmental tour of the facility, on 05/01/23 from 02:00 to 04:00 PM, with maintenance staff Z, revealed the following resident accessible areas contained the following areas/items with accident hazards to the residents of the facility. The 100 Hallway had two bulbs in each of four of the hallway ceiling lights, lacked any type of protective coverings to protect in case of broken glass any resident that may be walking under them if they broke. Maintenance staff Z verified the light bulbs lacked the protective coverings they should have. The large courtyard between hallways 100 and 300, contained a large cement pad in the middle. The cement was approximately 12 by 12 feet, and all edges were raised above the ground level, approximately 4 to 6 inches. These areas could cause any resident in the courtyard to trip and fall onto the cement pad. On the 200 Hallway a residents shower/toilet room on this hallway contained a shower with walls coming out to the front. The front corners of the shower contained tiles which were broken and cracked off in several areas along them. This presented a accident hazard for lower leg injury to any resident using this shower and coming in and out of the shower area. The same shower/toilet area contained metal grab bars for stability to get on and off of the toilet. One side grab bar was loose when grabbed, which could potentially cause a resident that might grab it to lose balance and fall. Maintenance staff Z verified the broken tiles and the loose grab bar could cause accidents to the residents. The 400 Hallway contained the facility special care unit with a resident census of 9. An unlocked residents' shower/toilet room contained multiple resident care items and personal belonging stored in the room's shower areas. The contents stored included pictures, suitcases, clothes, a wheelchair, two large plastic barrels, window blinds against the wall, decor items, and an oxygen tank caddy. This room was so full of items that it created a accident hazard for any of the 9 residents if they wandered into the room and tripped on the items. The special care unit's activity/snack room area contained a sink with cabinets along one side wall of the room. A large storage cabinet just inside this room doorway, stood open. The cabinet held a spray bottle of Spic and Span Disinfectant, to keep out of the reach of children hazard label. The same open cabinet contained a plastic open topped container, that held multiple different types/colors of fingernail polish. These should be kept out of the reach of children also. These hazardous chemicals were accessible to all 9 residents on the special care unit with impaired cognition. The 500 Hallway's southeast exit door entered into a courtyard. On this day the facility had a group of workers cleaning up this courtyard of old metal and tree limbs/trash. On 4/27/23 observation revealed the courtyard contained multiple old mechanical lifts and other old metal equipment, but today at this time they were removed. The courtyard did contain a cement pad, approximately 3 by 3 feet, which was raised along all the edges approximately 2 to 4 inches. Any resident in the courtyard could easily trip on this accident hazard. The facility failed to provide necessary housekeeping and maintenance services to maintain a safe environment for the residents of the facility.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 41302 The facility had a census of 70 residents. The sample included 18 residents with one resident reviewed for bed side rails. The facility had 11 residents with bed side rails in place. Based on observation, interview, and record review the facility failed to monitor the use of bed side rails for Resident (R) 4. This deficient practice placed R4 and the other 10 residents at risk for potentially serious injury. Findings included: - R4's Electronic Medical Record (EMR) documented diagnoses of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), acquired absence of the right leg below the knee (transtibial amputation that involves removing the lower leg), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The 05/28/22 Admission Minimum Data Set (MDS), documented R4 had a Brief Interview for Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS documented R4 required supervision assistance of one staff for bed mobility, and transfers. The MDS documented R4 had no range of motion (ROM) impairment, used a wheelchair and walker for mobility, and had no falls. The 04/04/23 Medicare Five-day MDS documented a BIMS of six, indicating severely impaired cognition. R4 required extensive assistance of two staff for bed mobility, transfers, and toilet use. The MDS documented R4 had ROM impairment on both upper extremities and one lower extremity. R4 had no falls. The 02/25/23 Care Plan, directed staff to place a non-slip product in R4's wheelchair and a device under the sheet to define the perimeter of the bed. The care plan lacked direction for the use of bed rails. The facility lacked a monitoring system for the use of bed side rails, for all 11 residents. The tour of the facility on 04/25/23 at 04:00 PM revealed 11 sets of bed side rails, eight of those assessments documented a no response to the use of bed side rails, with three stating yes to the use of bed side rails. On 04/24/23 at 01:16 PM, observation revealed R4 had bed side rails. On 04/25/23 at 03:18 PM, observation revealed R4 sat in his wheelchair in his room watching television. On 04/25/23 at 02:20 PM, Therapy Staff Y revealed she would assess residents for the use of positioning loops (bed side rails) and make a recommendation for the use of them. Therapy Staff Y revealed she would go to maintenance and have them place the rails. Therapy Staff Y confirmed she kept no documentation of the assessment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/23 at 02:25 PM, Maintenance Staff Z confirmed he would put the positioning bars in place when therapy recommended them. He was uncertain of any assessments, monitoring, or requirements for the bars. Maintenance Staff Z confirmed he had no documentation of the number of rails or monitoring of them. On 04/25/23 at 02:40 PM, Administrative Nurse B stated the facility did not use bed rails. She confirmed the bars on the beds were positioning loops. She stated therapy would assess residents for the use of the loops and maintenance would place them. Administrative Nurse B confirmed she was unaware of the number of or the monitoring of the positioning loops. The facility's December 2017 Bed Safety policy documented the facility maintenance staff would ensure that bed rails are properly installed, inspect all beds and related equipment, and ensure that all bed system components that need to be replaced or repaired are. The maintenance department shall provide a copy of inspections of the bed system components to the administrator if action was required. The facility failed to monitor for the use of bed side rails, placing R4 and the other 11 residents at risk for potentially serious injury.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility identified a census of 70 residents, which included 18 residents in the sample. Based on record reviews, the facility failed to ensure timely physician visits for Resident (R) 54, R43, and R25. Findings included: - R54 admitted to the facility on [DATE], but was not seen by the physician until 01/10/23, 98 days after admission. R54 was seen by the physician again on 04/05/23 and seen by the non-physician practitioner (NPP) on 10/11/22, 10/12/22, 12/07/22, 01/11/23 and 02/15/23. R43 admitted to the facility on [DATE], but was not seen by the physician until 01/10/23, 125 days after admission. The Electronic Health Record (EHR) lacked documentation of additional physician visits. R43 was seen by the NPP on 10/05/22, 10/19/22, 11/16/22, 12/14/22 and 01/17/23. R25 admitted to the facility on [DATE] and was seen by the physician on 07/22/22. The EHR lacked documentation of additional physician visits. R25 was seen by the NPP on 07/26/22, 08/03/22 and 08/10/22. The EHR lacked documentation of additional NPP visits. On 05/02/23 at 01:00 PM, Corporate Staff S acknowledged that the physician and NPP were not alternating their visits per facility expectation. The facility's Routine Standing Orders, dated 10/28/21 documented: 1. A resident must be seen by a physician at least once every 30 days for the first 90 days of admission. 2. After the first 90 days, a physician must see a resident at least every 60 days. The facility failed to ensure residents were seen by the physician within the required time frame. This had the potential for unrealized changes in the residents' conditions leading to unnecessary complications in their wellbeing.

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	175078	A. Building B. Wing	05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41302 The facility reported a census of 70 residents on five hallways, one being a locked dementia (progressive mental disorder characterized by failing memory, confusion) unit. Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services which included behavioral monitoring and staffing. The facility further failed to ensure adequate nursing staff to monitor medication administration as ordered by a physician, and to perform adequate monitoring of medications administered. Findings Included: - Upon entrance on 04/24/23 at 09:00 AM Administrative staff A informed the survey team the facility Director of Nursing (DON) quit two weeks ago, but the Minimum Data Set (MDS) nurse would be the acting interim DON. On 04/25/23 at 08:37 AM Certified Nurse Aide (CNA) I stated when both CNAs on the hall were performing cares on a resident who required two-person assistance, there was no staff left in the hallways to monitor the other residents on the hall (400). On 04/25/23 an anonymous resident stated it sure was interesting that when surveyors were in the facility, all the people from the offices came out and helped and wanted to be seen. The resident stated they did not come out of their offices any other time. On 04/26/23 an anonymous resident stated he was just left on the toilet for 45 minutes and had to holler out multiple times with his call light on to get someone to come help him off. He stated his butt hurt and that this was not the first time. On 04/27/23 at 03:00 PM R21 propelled his wheelchair down the hall with his urinary catheter drainage tubing dragging on the floor under his wheelchair. On 05/01/23 at 08:15 AM R216 sat in bed in her night clothes. The resident was agitated and yelled for someone to help her get up and out of bed. The resident had been yelling for quite some time (approximately 30 minutes) without staff checking in on her). On 05/01/23 at 08:52 AM a CNA revealed she did not think there was sufficient staff to be able to complete the required tasks for each resident and to be able to chart adequately. On 05/01/23 at 09:30 AM observation revealed a resident yelled for help and when the surveyor entered R216's room, she stated she had been waiting with her call light on for two hours for someone to help her get up for the day. R216 said she had her call light on the whole time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/01/23 at 09:40 AM the surveyor went to the nurses' station on 100 hall and asked if there were any Certified Nurse Aides (CNA) on the 500 hall. Administrative Staff A reported the CNA on the 200 hall was to care for the 500 hall, too. The surveyor informed her R216 reported her call light being on for two hours. The call light board showed R216's light on and had re-paged 12 times (each re-page is three minutes long; for a total of over 35 minutes) as the resident waited for help. Administrative Staff A stated the office people were helping on the floor and names were added to the schedule day sheet, including Activities Staff M. The surveyor asked Activities Staff M if she were working the floor, but she informed the surveyor she was not working the floor, she was in activities. Activities Staff M and Administrative Staff A walked with the surveyor to R216's room and found a therapy staff member with the resident R216, who had been hollering, so she helped the resident get up. Interview on 05/01/23 at 10:30 AM R216 reported she was here for rehabilitation and wanted to go home as soon as she could, but it was not helping her laying in this bed forever waiting on help to get up. She said she was trying to build her strength but could not if they were not going to help her. She said could do a lot for herself but with her fracture, she was limited. On 05/01/23 revealed a resident on the 500-hall received intravenous medication per electric pump. The pump had an alarm to alert the nurse when the medication administration was complete. The pump alarm sounded from 0910 to 0950 prior to the nurse disconnecting the pump from the resident. The pump alarmed for 40 minutes after the medication administration completed. On 05/01/23 at 02:56 PM, Administrative Nurse B stated if blank spots were found on the Medication Administration Record (MAR) or Treatment Administration Record (TAR), it indicated the staff were too busy to get it done. The facility failed to conduct a thorough investigation of the allegations of resident-to-resident abuse and failed to take appropriate corrective actions to protect residents from further abuse. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. (See F600) The facility failed to ensure residents were free from resident-to-resident abuse from 10/05/21 through 04/21/23, involving 19 residents. After each abuse incident, the facility did not report the incidents in a timely manner to the State Agency as required. This had the potential to affect all 70 residents. (See F609) The facility failed to provide a safe and secure living environment for the residents of the facility with the failure to accurately investigate, assess, and implement adequate immediate interventions to prevent the continued abuse of resident-to-residents, following these 14 incidents reviewed. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. (See F610) The facility failed to monitor the use of bed side rails for Resident (R)4. This deficient practice placed R4 and the other 10 residents at risk for potentially serious injury. (See F700) Based on observation, interview, and record review the facility failed to incorporate the recommendations from a Preadmission Screening and Resident Review (PASRR) level II evaluation report into (R)12's assessment, care plan, and/or a transition of care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation and interview, the facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in resident areas including on five of the five resident hallways, the dining room, the beauty shop, and in courtyards, for the residents of the facility. Based on interview and record review the facility failed to ensure Certified Nurse Aides (CNA) received an annual evaluation for three of five staff reviewed to ensure the care provided to the residents for their highest practicable level of well-being. Based on interview, observation, and record review, the facility failed to protect the privacy and dignity of Residents (R) 52 and R42. This deficient practice led to R42 being able to be around multiple other residents with visibly soiled clothing and R52 living in a malodorous environment. Based on record review and interview, the facility failed to conduct Quality Assurance and Performance Improvement (QAPI) committee meetings with the required members present, which included having the Medical Director present at the meetings. This had the potential to affect all residents. The facility failed to ensure Resident (R) 50 and R57 were monitored for side effects of extrapyramidal (abnormal involuntary body movements caused by medications) symptoms due to antipsychotic (a class of medication used to treat psychosis and other mental emotional conditions) medication use, failed to monitor R50 and R48 for behaviors related to antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication use and antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension The facility failed to develop a comprehensive care plan for one resident of 18 residents reviewed for care plans. Resident (R) 216. (See F656) The facility failed to provide timely care to skilled Resident (R) 216, who was in rehabilitation, with plans to return home. (See F676) The facility's Staffing policy dated November 2017 documented that the facility maintained adequate staffing, with the skills and competencies, on each shift to ensure that the resident's needs and services were met. The facility failed to have sufficient nursing staff to provide nursing and related services to maintain each resident's highest practicable physical well-being, safety, and quality of care.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41302 The facility reported a census of 70 residents, with 18 residents sampled. Based on observation, interview, and record review the facility failed on four days to have Registered Nurse (RN) coverage for at least eight hours daily in the last three months. Findings included: - The facility provided Census Report dated 04/24/23 noted 70 residents resided in the facility. On 04/24/22 at 07:30 AM, observation revealed 70 residents resided in the facility. Review of the nursing schedules for February 01, 2023, through April 24, 2023, documented four days with no continuous eight hours of RN coverage (02/11/23, 03/04/23, 04/09/23, and 04/15/23). On 04/27/23 at 10:30 AM, Administrative Staff A verified the facility lacked continuous eight-hour RN coverage for the four dates. She confirmed they had tried to cover every day. The facility's Staffing policy revised October 2017 lacked documentation of the RN coverage requirement. The facility failed to RN coverage at least eight hours daily for the 70 residents who resided in the facility, placing the residents at risk for unsupervised nursing care and services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 41302 The facility reported a census of 70 residents. Based on interview and record review the facility failed to ensure Certified Nurse Aides (CNA) received an annual evaluation for three of five staff reviewed to ensure the care provided to the residents for their highest practicable level of well-being. Findings Include: - Review of five Certified Nurse Aides (CNA) records (with employment for the facility documented as more than one year) revealed lack of documentation of annual evaluations for three of the five CNAs reviewed. (CNA L, CNA V, and CNA W). On 04/27/23 at 02:01 PM Administrative Staff A confirmed the facility was behind on the evaluations of the staff. The October 2017 facility Staffing policy lacked any direction/information/documentation that addressed the CNA annual evaluation. The facility failed to provide annual evaluations for three of the five CNAs reviewed to ensure the highest practicable level of well-being for each resident.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 41302 The facility census totaled 70 residents, with 18 residents included in the sample. Based on interview and record review the facility failed to ensure sufficient competent staffing to address the behavior health needs of the residents to provide a safe environment. Findings included: - Review of R31's Physician's Progress Note, dated 04/24/23, documented the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), bipolar (major mental illness that caused people to have episodes of severe high and low moods), and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness). The 04/18/23 Annual Minimum Data Set (MDS), documented, per staff interview, R31 had severely impaired cognition. R31 had inattention that would fluctuate, and physical and other behaviors towards others exhibited one to three days during the seven-day review period, that would interfere with her care and impair her activities, as well as intrude on the privacy of others. The assessment also noted R31 wandered and rejected care one to three days during the seven-day review period, and would intrude on the privacy or activities of others. R31 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications daily during the seven-day review period. He required staff supervision for mobility. The 04/18/23 Psychotropic Drug Use Care Area Assessment (CAA), documented R31 had diagnoses that could impact her behaviors. R31 was alert to her name only, but could no longer recognize she was in a nursing home. R31's speech was garbled; an occasional word came out clearly. R31 did occasionally reject cares, but could be redirected by another staff member most of the time. R31 did wander around the memory unit frequently. The 12/13/16 Care Plan advised staff to monitor and record occurrences of targeted behavior symptoms, such as lying, stealing, and verbal altercations. The care plan directed staff to provide emotional support, encouragement, and allow R31 to vent feelings. The 12/08/22 Resident to Resident Facility Self-Investigation documented on 12/08/22 R31 pushed R21 causing her to fall. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 12/08/22. The 01/02/23 Resident to Resident Facility Self-Investigation documented on 01/02/23 R31 pushed R177. The investigation lacked resident interviews, identification of causal factors, and witness statements. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Note for R31 lacked documentation of the incident on 01/02/23. The 01/10/23 Behavior Note documented R31 was physically aggressive with staff when they attempted to assist her with toileting needs following an incontinent episode. R31 was hitting and kicking staff. The 02/15/23 Resident to Resident Facility Self-Investigation documented on 02/15/23 R57's spouse reported R57 had a bruise. Through investigation of video recordings, it was determined R31 entered R57's room. The investigation lacked resident interviews, identification of causal factors, and witness statements. The Progress Note for R31 lacked documentation of the incident on 02/15/23. Review of an undated Relias (a computer-generated education program) Dementia Care provided in-service by the facility revealed no information on the content of the education provided however, indicated all staff members completed the training. Observation of R31 on 04/26/23 at 04:14 PM, revealed R31was calmly ambulating up and down the memory unit hall. On 04/26/23 the 400 hallway was observed from 10:50 AM to 10:57 AM without a staff member present, with two residents walking in hallway, both staff assigned to hall were providing needed care to the same resident. On 04/27/23 at 04:30 AM hall 400 had a slight odor of urine in hallway when entering from main building area (not the entry from the 500 hall) staff were not easily visible, until surveyor was able to walk the entire length of the hallway. The odor of urine steadily increased while approaching rm 411. When both staff were questioned about the odor, they stated they were unaware of it. On 04/27/23 at 04:40 AM Certified Nurse Aide (CNA) E stated she had not noticed the odor of urine, but stated that R52's mattress was probably soaked in urine as he became aggressive with staff when staff attempted to clean him up following incontinent episodes. CNA E stated that during an incident on the unit one staff member would intervene and the other would go get the nurse. In the event of one staff member present on the unit, such as at night, they could use the call light system or their personal cell phones. On 04/27/23 at 04:40 AM CNA AA stated she had not noticed the odor of urine in the hall. CNA AA stated that while on the memory unit (hall 400) if she required assistance, she could use the call lights as other staff would be aware it was staff as the residents on the memory care unit did not possess the cognitive ability to use the call light system. CNA AA stated that to work on the memory unit staff had to complete an hour-long module with a test. On 04/27/23 the 400 hallway was observed from 05:30 AM till 05:37 AM with two residents ambulating in the hallway and no staff presence. On 05/01/23 at 09:18 AM Licensed Nurse (LN) C confirmed R31 had been in some resident-to-resident altercations, but stated that she was doing better now. She could not list an intervention that helped. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/01/23 at 02:56 PM Administrative Nurse B confirmed R31 had had altercations, that a thorough investigation had was completed, and that she could not list any interventions for the altercations. The facility's' March 2019 Behavior Assessment, Intervention and Monitoring documented that the interdisciplinary team would monitor the residents. The policy lacked any qualifications for staffing to provide care to the population of the memory unit. The facility failed to provide sufficient staff with appropriate competencies and tools to provide nursing services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well being of each resident on the memory unit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46960 The facility census reported 70 residents with 18 residents sampled, that included five residents sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to follow the physician's orders for Resident (R)50, related to physician ordered insulin. This failure placed the resident at risk for adverse effects related to medication use. Findings included: - R50's diagnoses from the Electronic Health Record (EHR) included diabetes mellitus, type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The 11/15/22 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of six, indicating severely impaired cognition. R50 received insulin injections five days in the seven-day look-back period. The 02/15/23 quarterly MDS documented the resident had a BIMS of 11, indicating moderately impaired cognition. R50 received insulin injections daily in the seven-day look-back period. The 11/15/22 Care Area Assessment (CAA) lacked documentation related to insulin use. The 04/24/23 Care Plan documented instructions for staff to educate resident/family/caregivers in correct protocol for glucose monitoring and administration of insulin. Staff were to administer medication for diabetes as ordered by the physician. Additionally documented instructions for staff to obtain fasting blood sugar level and report to physician if below 60 or greater than 500 milligrams/deciliter (mg/dL). The Electronic Health Record (EHR) included the following physician orders: 1. Humalog insulin 100unit/mL (milliliter) - inject per sliding scale: if [blood glucose is] 150-199 [inject] 2 units; [if blood glucose is] 200-249 [inject] 4 units; [if blood glucose is] 250-299 [inject] 6 units; [if blood glucose is] 300-349 [inject] 8 units; [if blood glucose is] 350-399 [inject] 10 units subcutaneously (SQ - beneath the skin) with meals for diabetes and inject 10 units SQ with meals for diabetes, ordered 11/11/22. 2. Insulin Glargine 100unit/mL - inject 30 units subcutaneously at bedtime for diabetes, ordered 11/11/22. Review of the physician's orders lacked a specific order with blood sugar parameters to withhold medication and/or notify the physician. Review of the 11/2022 to 04/2023 Medication Administration Record (MAR) revealed the following concerns: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. From 11/11/22 to 04/30/22, for scheduled insulin doses and blood sugar readings, 66 doses omitted. 2. From 11/11/22 to 04/30/22, for sliding scale insulin doses and blood sugar readings, 45 entries omitted. 3. From 11/11/22 to 04/30/22, for all insulin doses, 21 entries were documented where the insulin was held with the rationale that the blood sugar readings were between 95 and 145 mg/dL. The Progress Notes lacked documentation that the physician was notified of insulin having been held with rationale. On 05/01/23 at 09:08 AM, Licensed Nurse (LN) C revealed if a medication is not documented on the MAR, then it wasn't given or done, for example, blood sugar levels or insulin administrations. Furthermore, LN G stated that if a nurse felt the insulin should be held, then staff should notify the physician for an order clarification. On 05/01/23 at 02:47 PM, LN H revealed that if a resident's blood sugar reading was below the sliding scale, staff should hold the insulin, but no physician notification was required. On 05/01/23 at 02:56 PM, Administrative Nurse B stated that if something wasn't charted, it wasn't done. Further, Administrative Nurse B revealed that missing entries on the MAR indicates that staff were too busy with other tasks to get it done. Additionally, stated that this problem has been addressed by administration and was aware of the problem. Administrative Nurse B stated that staff should not be holding insulin doses without physician notification, except if a resident refused a dose, and this action should still be documented. The facility's Routine Standing Orders dated 10/18/21 instructed that staff to administer source of protein if blood sugar was less than 90mg/dL. Further instructed staff to notify physician if blood sugar was less than 60mg/dL or above 500mg/dL if the resident did not have parameters specified in their physician orders. Lacked instructions about when or if staff were to hold or omit insulin doses. The facility's Medication Therapy policy, dated 04/2007 lacked instructions related to insulin administration. The facility's Medication Holds policy, dated 04/2007 documented that medication holds can be ordered by the resident's physician, but lacked information related to individual doses of insulins. The facility failed to follow physician's orders for R50 related to insulin not being administered as the physician ordered. This placed the resident at risk for adverse effects related to medication use.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility census totaled 70 residents with 18 included in the sample including five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure the residents were free of unnecessary medications by the failure to follow-up timely on pharmacy consultant recommendations for Resident (R) 25, R48, R50, and R57. These failures placed the residents at risk for adverse effects related to medication use. Findings included: - R25's pertinent diagnoses from the Electronic Health Record documented cerebral infarction affecting left non-dominant side (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),major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), atherosclerosis of native arteries of leg with ulceration of the left ankle (where the arteries become narrowed and hardened due to buildup of plaque (fats) in the artery wall), pain, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). Review of R25's Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of two staff for daily care. The resident was admitted with three venous and arterial ulcers. The resident stated almost constant pain in wounds. Medications received included antianxiety, antidepressant, hypnotic, antibiotic, diuretic, and opioid pain medications. Review of the Quarterly MDS dated [DATE] revealed no significant changes in cognition, daily cares, or medications since the Admission MDS dated [DATE]. The Physicians Orders documented an order dated 08/25/22 for Bupropion HCL ER Tablet Extended Release, 12 Hour 150 MG. Give 150 mg by mouth two times a day for depression The Physicians Orders on 08/25/22 included: Anti-Depressant Medication: Observe Resident Closely for significant side effects as follows: Sedation, Drowsiness, Dry Mouth, Blurred Vision, Urinary Retention, Tachycardia, Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity, Excessive Weight Gain. Document 'N' if none observed. Document 'Y' and chart findings under progress notes. every shift Behavior monitoring: Document 'Y' for yes if behaviors are present and chat in progress notes the behavior observed and any non-pharmacological interventions prior to use of any behavioral medications. Document 'N' if no behaviors observed or reported every shift. Review of the Medication Administration Record for 04/2023 revealed nurses initialed behavior monitoring, though failed to identify whether the resident had behaviors. Review of the Consulting Pharmacist Monthly Medication review revealed the following: (continued on next page)

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	175078	A. Building B. Wing	05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at College Hill	5005 E 21st Street North Wichita, KS 67208

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/28/23, Antidepressant Gradual Dose Reduction (GDR) attempt reduction of Bupropion XL 100 mg by mouth (PO) twice a day (BID). Physician replied on 02/07/23 with: The resident's target symptoms returned or worsened after previous attempts as GDR. Observation and interview on 04/25/23 at 08:53 AM revealed the resident propelled in her electric chair towards her room. The resident looked tired and when asked stated she did not sleep well due to pain in her feet and legs. She stated she had neuropathy and wounds on her feet and legs starting in another facility from a brown spider bite. Observation on 05/01/23 at 11:30 AM revealed the resident slowly propelling her chair through the hall. The resident smiled a little when greeted and her feet were wrapped per usual. On 05/01/23 at 11:30 AM Licensed Nurse X reported the resident came to the facility last summer with the wounds and received dressing changes. Nurse X did not know the residents behaviors were not charted the correct way. The facility failed to provide contact information for consultant pharmacist as requested on 04/24/23. The facility failed to ensure R25 was free of unnecessary medications by the failure to follow-up timely on pharmacy consultant recommendations for Resident (R) 25. - Resident (R)48's signed Physician Orders dated 04/05/23 revealed diagnoses: unspecified dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident had no documented behaviors. The resident required extensive to limited assistance of one staff with daily cares. The resident received pain medication on schedule for pain rated at 8 out of 10. R48's medications included antianxiety, antidepressant, anticoagulant, and opioid pain medication. The Physician Orders dated 04/05/23 revealed: 04/05/23: Tramadol HCl Oral Tablet (pain medication) 50 milligrams (MG), Give 1 tablet by mouth (PO) every 12 hours, as needed for pain. 04/05/23: Trazodone HCl Oral Tablet 50 mg, Give 1 tablet PO, at bedtime for insomnia. 04/05/23: Norco Oral Tablet (opioid pain medication)7.5-325 mg (Hydrocodone-Acetaminophen), give 1 tablet PO, four times a day, for pain. 04/05/23: Buspirone HCl Oral Tablet 10 mg, give 1 tablet PO, three times, a day for anxiety. 04/05/23: Lexapro Oral Tablet 20 mg, give 1 tablet PO, at bedtime for depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Anti-Depressant medication: Observe resident closely for significant side effects as follows: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity, excessive weight gain. Document 'N' if none observed. Document 'Y' and chart findings under progress notes, Every shift. Behavior monitoring: Document 'Y' for yes if behaviors are present and chat in progress notes the behavior observed and any non-pharmacological interventions prior to use of any behavioral medications. Document 'N' if no behaviors observed or reported. Every shift Review of the Pharmacist Monthly Medication Regimen Review revealed: 07/28/22, Antidepressant gradual dose reduction (GDR) attempt for Escitalopram 20 mg day andTrazadone 150 mg bedtime (HS).The 08/09/22 Physician response: Escitalopram do not reduce- target symptoms returned or worsened after previous attempt. Decrease Trazadone to 100 mg PO HS. 08/29/22, Anxiolytic GDR attempt for Buspirone (antianxiety medication) 10 mg three times a day (TID). The physician response: do not reduce- target symptoms returned or worsened after previous attempt 12/29/22, See report Psychotropic GDR attempt for Buspirone and Escitalopram. Physician response: Do not reduce target symptoms returned or worsened after previous attempt of both medications. 04/25/23 at 01:16 PM the resident worked with the therapist and used a trapeze bar to sit up and transfer himself to his wheelchair. The resident was pleasant and visited with the therapist during cares and no anxiety noted with the session. On 04/26/23 at 03:50 PM Certified Nurse Aide (CNA) K reported the resident had some pain but not that often. He needed assistance of two to transfer from his bed to his chair or to his toilet. He had no bad behaviors, he would just call out loudly for staff, rather than use his call light for help. On 05/01/23 at 11:30 AM Licensed Nurse X reported the resident was non-compliant. He would cooperate with care without behaviors. We monitor behaviors and side effects for the resident every shift. She did not know the monitoring was not put back on the medication administration record when the resident returned from the hospital on 04/05/23. The facility's Behavioral Assessment, Intervention and Monitoring policy dated 03/2019 documents that behavioral symptoms would be identified using facility-approved behavioral screening tools. Further that staff documentation would include monitoring of efficacy and adverse consequences. Additionally documents that if a resident is being treated for altered behavior that staff would document any improvements or worsening of target behavior, mood and/or function. The facility failed to ensure R25 was free of unnecessary medications by the failure to follow-up timely on pharmacy consultant recommendations for R48. 46960 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R57's pertinent diagnoses from the Electronic Health Record (EHR) documented dementia (a progressive mental disorder characterized by failing memory, confusion) with agitation, other frontotemporal neurocognitive disorder (a progressive disease of the brain affecting the frontal and temporal lobes of the brain resulting in behavior outbursts, trouble communicating and base personality changes) and unspecified speech disturbances. R57's Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) by staff assessment indicating memory problems with severely impaired cognition. No abnormal behaviors were documented during the seven-day look back period. The resident received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) daily during the seven-day look back period. R57's Quarterly MDS, dated [DATE] documented a BIMS by staff assessment indicating memory problems with severely impaired cognition. The resident had other behaviors not directed towards others one to three days during the seven-day look back period, and rejection of care and wandering one to three days during the seven-day look back period. The resident received an antipsychotic medication daily in the seven-day look back period. Review of the Psychotropic Drug Use Care Area Assessment (CAA), dated 12/05/22 documented use of psychotropic (classes of medications that affect the mind, mood, or mental processes) medication usage daily. Review of the Cognitive Loss/Dementia CAA, dated 12/05/22 documented R57 was nonverbal documented use of psychotropic medication usage daily. The Care Plan dated 04/26/23 lacked instructions specific for staff to monitor behaviors related to psychotropic medication use. The Electronic Health Record (EHR) Physician Orders included: 1. Risperidone (Risperdal) 0.25 milligrams (mg) to be given two times daily for behavioral disturbances, dated 11/28/22. The order lacked information specific to monitoring of behaviors. Review of the EHR for abnormal involuntary movement scale (AIMS) assessments documented staff completed assessments on 01/23/23 with results of zero which indicated no abnormal movements. However, the facility lacked additional AIMS examinations. The 02/01/23 to 04/25/23 Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) clinical records lacked behavior monitoring or mood monitoring. The Medication Regimen Review (MRR) documents reviewed from 11/29/22 to 04/11/23 lacked recommendations from pharmacist related to monitoring of behaviors related to psychotropic (classes of medications [antidepressant, antipsychotic, antianxiety] that affect the mind, mood, or mental processes) medication use. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/26/23 at 12:28 PM, Certified Nurse Aide (CNA) L revealed behaviors were charted on all residents in the special care unit. On 05/01/23 at 09:18 AM, Licensed Nurse (LN) C reported AIMS assessments should be completed at admission and every three months thereafter on all residents who received psychotropic medications. In addition, LN C revealed if something was not documented, it was not done. On 05/01/23 at 02:47 PM, LN H revealed for staff to be able to document behaviors on the ETAR, a specific physician order must exist. On 05/01/23 at 02:56 PM, Administrative Nurse B confirmed the absence of behavior monitoring on the ETAR for R50. Further, Administrative Nurse B stated any resident who was on psychotropic medications should have behavior monitoring performed by licensed staff. Additionally, Administrative Nurse B stated the monitoring of behaviors could be initiated by any licensed nurse and did not require a physician order. The facility failed to provide contact information for consultant pharmacist as requested on 04/24/23. The facility's Antipsychotic Medication Use policy dated 03/2015 lacked instructions about how staff were to monitor behaviors of residents taking psychotropic medications. The facility's Medication Therapy policy, dated 04/2007, documented that the medical director and consultant pharmacist shall collaborate to address medication monitoring with staff. The facility's Tapering Medications and Gradual Drug Dose Reduction policy, dated 04/2007, lacked instructions for staff to monitor behaviors of residents taking psychotropic medications. The facility's Behavioral Assessment, Intervention and Monitoring policy dated 03/2019 documents that behavioral symptoms would be identified using facility-approved behavioral screening tools. Further that staff documentation would include monitoring of efficacy and adverse consequences. Additionally documents that if a resident is being treated for altered behavior that staff would document any improvements or worsening of target behavior, mood and/or function. The consultant pharmacist failed to ensure staff monitored R57 for side effects, such as abnormal involuntary body movements, caused by medications. In addition, the facility failed to adequately monitor the resident for behaviors or mood changes. - R50's pertinent diagnoses from the Electronic Health Record (EHR) documented Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and generalized anxiety disorder (a disorder characterized by chronic free-floating anxiety and such symptoms as tension or sweating or trembling or lightheadedness or irritability etc. that has lasted for more than six months) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R50's Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of six, indicating severely impaired cognition. The resident had verbal behaviors directed towards others one to three days in the seven-day look back period, with verbal and behavioral symptoms not directed towards others one to three days in the seven-day look back period. The resident received an antianxiety medication five out of seven days in the look-back period. R50's Quarterly MDS, dated [DATE] documented a BIMS of 11, indicating moderately impaired cognition. The resident had verbal behaviors directed towards others one to three days during the seven-day look back period, and other behavioral symptoms not directed at others four to six days during the seven-day look back period. The resident received antipsychotic, antidepressant, and antianxiety medications daily in the seven-day look back period. Review of the Psychotropic Drug Use Care Area Assessment (CAA), dated 11/15/22 documented use of psychotropic (classes of medications that affect the mind, mood, or mental processes) medication usage. The CAA further, documented for staff to monitor for side effects and effectiveness of medication usage. Additionally, the CAA documented for staff to monitor and document on the electronic treatment administration record E-TAR and electronic medication administration record EMAR. Finally, the CAA documented medications would be reviewed monthly by a pharmacist for any potential gradual dose reductions (GDR). The care plan documented: On 01/21/23 the resident had a behavior problem related to yelling and instructed staff to document behaviors and potential causes. On 02/12/23 noted the resident used of Buspar (buspirone, an antianxiety medication) and Seroquel (quetiapine, an antipsychotic medication) and instructed staff to monitor and record target behavior symptoms and document per facility protocol. On 02/12/23 noted the use of Zoloft (sertraline, an antidepressant medication) and instructed staff that R50 was to be monitored by licensed staff and behaviors recorded on the ETAR. The EHR Physician Orders included: 1. Buspar (buspirone) 10 milligrams (mg) to be given orally three times a day for anxiety, dated 04/13/23. 2. Seroquel (quetiapine) 25 mg to be given once time daily for anxiety, dated 03/29/23. 3. Zoloft (sertraline) 75 mg to be given one time a day for depression, dated 02/08/23. The record lacked orders specific to monitoring of behaviors. Review of the EHR for abnormal involuntary movement scale (AIMS assessment tool) assessments documented staff completed assessments on 11/11/22 with results of three indicating mild abnormal movements. However, the facility lacked additional AIMS examinations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/2022 to 04/2023 EMAR and ETAR clinical records lacked behavior monitoring or mood monitoring. The Medication Regimen Review (MRR) documents reviewed from 11/29/22 to 04/11/23 lacked recommendations from pharmacist related to monitoring of behaviors related to psychotropic (classes of medications [antidepressant, antipsychotic, antianxiety] that affect the mind, mood or mental processes) medication use. On 04/26/23 at 12:28 PM, Certified Nurse Aide (CNA) L revealed behaviors were charted on all residents in the special care unit. On 05/01/23 at 09:18 AM, Licensed Nurse (LN) C reported AIMS assessments should be completed at admission and every three months thereafter on all residents who received psychotropic medications. In addition, LN C revealed that if something was not documented, it was not done. On 05/01/23 at 02:47 PM, LN H revealed for staff to be able to document behaviors on the ETAR, a specific physician order must exist. On 05/01/23 at 02:56 PM, Administrative Nurse B confirmed the absence of behavior monitoring on the ETAR for R50. Further, Administrative Nurse B stated any resident who was on psychotropic medications should have behavior monitoring performed by licensed staff. Administrative Nurse B stated monitoring of behaviors could be initiated by any licensed nurse and did not require a physician order. The facility failed to provide contact information for consultant pharmacist as requested on 04/24/23. The facility's Antipsychotic Medication Use policy dated 03/2015 lacked instructions about how staff were to monitor behaviors of residents taking psychotropic medications. The facility's Medication Therapy policy, dated 04/2007, documented the medical director and consultant pharmacist shall collaborate to address medication monitoring with staff. The facility's Tapering Medications and Gradual Drug Dose Reduction policy, dated 04/2007 ,lacked instructions for staff to monitor behaviors of residents taking psychotropic medications. The facility's Behavioral Assessment, Intervention and Monitoring policy dated 03/2019 documents that behavioral symptoms would be identified using facility-approved behavioral screening tools. Further that staff documentation would include monitoring of efficacy and adverse consequences. Additionally documents that if a resident is being treated for altered behavior that staff would document any improvements or worsening of target behavior, mood and/or function. The consultant pharmacist failed to ensure staff monitored R50 for side effects such as abnormal involuntary body movements caused by medications. In addition, the facility failed to monitor the resident for behaviors or mood changes.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 70 residents with 18 residents selected for review and included five residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure Resident (R) 50 and R57 were monitored for side effects of extrapyramidal (abnormal involuntary body movements caused by medications) symptoms due to antipsychotic (a class of medication used to treat psychosis and other mental emotional conditions) medication use, failed to monitor R25 and R48 for behaviors related to antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication use and antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension). Findings included: - R50's pertinent diagnoses from the Electronic Health Record (EHR) documented Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and generalized anxiety disorder (a disorder characterized by chronic free-floating anxiety and such symptoms as tension or sweating or trembling or lightheadedness or irritability etc that has lasted for more than six months) R50's Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of six, indicating severely impaired cognition. The resident had verbal behaviors directed towards others one to three days in the seven-day look back period, with verbal and behavioral symptoms not directed towards others one to three days in the seven-day look back period. The resident received an antianxiety medication five out of seven days in the look-back period. R50's Quarterly MDS, dated [DATE] documented a BIMS of 11, indicating moderately impaired cognition. The resident had verbal behaviors directed towards others one to three days during the seven-day look back period, and other behavioral symptoms not directed at others four to six days during the seven-day look back period. The resident received antipsychotic, antidepressant, and antianxiety medications daily in the seven-day look back period. Review of the Psychotropic Drug Use Care Area Assessment (CAA), dated 11/15/22 documented use of psychotropic (classes of medications that affect the mind, mood, or mental processes) medication usage. The CAA further, documented for staff to monitor for side effects and effectiveness of medication usage. Additionally, the CAA documented for staff to monitor and document on the electronic treatment administration record E-TAR and electronic medication administration record EMAR. Finally, the CAA documented medications would be reviewed monthly by a pharmacist for any potential gradual dose reductions (GDR). The care plan documented: On 01/21/23 the resident had a behavior problem related to yelling and instructed staff to document behaviors and potential causes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/12/23 noted the resident used of Buspar (buspirone, an antianxiety medication) and Seroquel (quetiapine, an antipsychotic medication) and instructed staff to monitor and record target behavior symptoms and document per facility protocol. On 02/12/23 noted the use of Zoloft (sertraline, an antidepressant medication) and instructed staff that R50 was to be monitored by licensed staff and behaviors recorded on the ETAR. The EHR Physician Orders included: 1. Buspar (buspirone) 10 milligrams (mg) to be given orally three times a day for anxiety, dated 04/13/23 2. Seroquel (quetiapine) 25mg to be given once time daily for anxiety, dated 03/29/23. 3. Zoloft (sertraline) 75mg to be given one time a day for depression, dated 02/08/23. The record lacked orders specific to monitoring of behaviors. Review of the EHR for abnormal involuntary movement scale (AIMS assessment tool) assessments documented staff completed assessments on 11/11/22 with results of three indicating mild abnormal movements. However, the facility lacked additional AIMS examinations. The 11/2022 to 04/2023 EMAR and ETAR clinical records lacked behavior monitoring or mood monitoring. The Medication Regimen Review (MRR) documents reviewed from 11/29/22 to 04/11/23 lacked recommendations from pharmacist related to monitoring of behaviors related to psychotropic (classes of medications [antidepressant, antipsychotic, antianxiety] that affect the mind, mood or mental processes) medication use. On 04/26/23 at 12:28 PM, Certified Nurse Aide (CNA) L revealed behaviors were charted on all residents in the special care unit. On 05/01/23 at 09:18 AM, Licensed Nurse (LN) C reported AIMS assessments should be completed at admission and every three months thereafter on all residents who received psychotropic medications. In addition, LN C revealed that if something wasn't documented, it wasn't done. On 05/01/23 at 02:47 PM, LN H revealed for staff to be able to document behaviors on the ETAR, a specific physician order must exist. On 05/01/23 at 02:56 PM, Administrative Nurse B confirmed the absence of behavior monitoring on the ETAR for R50. Further, Administrative Nurse B stated that any resident who was on psychotropic medications should have behavior monitoring performed by licensed staff. Administrative Nurse B stated monitoring of behaviors could be initiated by any licensed nurse and did not require a physician order. The facility failed to provide contact information for consultant pharmacist as requested on 04/24/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Antipsychotic Medication Use policy dated 03/2015 lacked instructions about how staff were to monitor behaviors of residents taking psychotropic medications. The facility's Medication Therapy policy, dated 04/2007, documented the medical director and consultant pharmacist shall collaborate to address medication monitoring with staff. The facility's Tapering Medications and Gradual Drug Dose Reduction policy dated 04/2007 lacked instructions for staff to monitor behaviors of residents taking psychotropic medications. The facility's Behavioral Assessment, Intervention and Monitoring policy dated 03/2019 documents that behavioral symptoms would be identified using facility-approved behavioral screening tools. Further that staff documentation would include monitoring of efficacy and adverse consequences. Additionally documents that if a resident is being treated for altered behavior that staff would document any improvements or worsening of target behavior, mood and/or function. The facility failed to ensure staff monitored R50 for side effects such as abnormal involuntary body movements caused by medications. In addition, the facility failed to monitor the resident for behaviors or mood changes. - R57's pertinent diagnoses from the Electronic Health Record (EHR) documented dementia (a progressive mental disorder characterized by failing memory, confusion) with agitation, other frontotemporal neurocognitive disorder (a progressive disease of the brain affecting the frontal and temporal lobes of the brain resulting in behavior outbursts, trouble communicating and base personality changes) and unspecified speech disturbances. R57's Admission Minimum Data Set (MDS), dated [DATE], documented a brief interview for mental status (BIMS) by staff assessment indicating memory problems with severely impaired cognition. No abnormal behaviors were documented during the seven-day look back period. The resident received an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) daily during the seven-day look back period. R57's Quarterly MDS, dated [DATE] documented a BIMS by staff assessment indicating memory problems with severely impaired cognition. The resident had other behaviors not directed towards others one to three days during the seven-day look back period, and rejection of care and wandering one to three days during the seven-day look back period. The resident received an antipsychotic medication daily in the seven-day look back period. Review of the Psychotropic Drug Use Care Area Assessment (CAA), dated 12/05/22 documented use of psychotropic (classes of medications that affect the mind, mood or mental processes) medication usage daily. Review of the Cognitive Loss/Dementia CAA), dated 12/05/22 documented R57 was nonverbal documented use of psychotropic medication usage daily. The Care Plan dated 04/26/23 lacked instructions specific for staff to monitor behaviors related to psychotropic medication use. The Electronic Health Record (EHR) Physician Orders included: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Risperidone (Risperdal) 0.25 milligrams (mg) to be given two times daily for behavioral disturbances, dated 11/28/22. The order Lacked information specific to monitoring of behaviors. Review of the EHR for abnormal involuntary movement scale (AIMS is an assessment tool) assessments documented staff completed assessments on 01/23/23 with results of zero which indicated no abnormal movements. However, the facility lacked additional AIMS examinations. The 02/01/23 to 04/25/23 Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) clinical records lacked behavior monitoring or mood monitoring. The Medication Regimen Review (MRR) documents reviewed from 11/29/22 to 04/11/23 lacked recommendations from pharmacist related to monitoring of behaviors related to psychotropic (classes of medications [antidepressant, antipsychotic, antianxiety] that affect the mind, mood or mental processes) medication use. On 04/26/23 at 12:28 PM, Certified Nurse Aide (CNA) L revealed behaviors were charted on all residents in the special care unit. On 05/01/23 at 09:18 AM, Licensed Nurse (LN) C reported AIMS assessments should be completed at admission and every three months thereafter on all residents who received psychotropic medications. In addition, LN C revealed if something was not documented, it was not done. On 05/01/23 at 02:47 PM, LN H revealed for staff to be able to document behaviors on the ETAR, a specific physician order must exist. On 05/01/23 at 02:56 PM, Administrative Nurse B confirmed the absence of behavior monitoring on the ETAR for R50. Further, Administrative Nurse B stated any resident who was on psychotropic medications should have behavior monitoring performed by licensed staff. Additionally, Administrative Nurse B stated the monitoring of behaviors could be initiated by any licensed nurse and did not require a physician order. The facility failed to provide contact information for consultant pharmacist as requested on 04/24/23. The facility's Antipsychotic Medication Use policy, dated 03/2015 lacked instructions about how staff were to monitor behaviors of residents taking psychotropic medications. The facility's Medication Therapy policy, dated 04/2007, documented that the medical director and consultant pharmacist shall collaborate to address medication monitoring with staff. The facility's Tapering Medications and Gradual Drug Dose Reduction policy, dated 04/2007 lacked instructions for staff to monitor behaviors of residents taking psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Behavioral Assessment, Intervention and Monitoring policy, dated 03/2019 documents that behavioral symptoms would be identified using facility-approved behavioral screening tools. Further that staff documentation would include monitoring of efficacy and adverse consequences. Additionally documents that if a resident is being treated for altered behavior that staff would document any improvements or worsening of target behavior, mood and/or function. The facility failed to ensure staff monitored R57 for side effects, such as abnormal involuntary body movements, caused by medications. In addition, the facility failed to adequately monitor the resident for behaviors or mood changes. 31078 - R25's pertinent diagnoses from the Electronic Health Record documented cerebral infarction affecting left non-dominant side (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),major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), atherosclerosis of native arteries of leg with ulceration of the left ankle (where the arteries become narrowed and hardened due to buildup of plaque (fats) in the artery wall), pain, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). Review of R25's Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of two staff for daily care. The resident was admitted with three venous and arterial ulcers. The resident stated almost constant pain in wounds. Medications received included antianxiety, antidepressant, hypnotic, antibiotic, diuretic, and opioid pain medications. Review of the Quarterly MDS dated [DATE] revealed no significant changes in cognition, daily cares, or medications since the Admission MDS dated [DATE]. The Physicians Orders documented an order dated 08/25/22 for Bupropion HCL ER Tablet Extended Release, 12 Hour, 150 mg. Give 150 mg by mouth two times a day for depression The Physicians Orders on 08/25/22 included: Anti-Depressant Medication: Observe Resident Closely for significant side effects as follows: Sedation, Drowsiness, Dry Mouth, Blurred Vision, Urinary Retention, Tachycardia, Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity, Excessive Weight Gain. Document 'N' if none observed. Document 'Y' and chart findings under progress notes. every shift Behavior monitoring: Document 'Y' for yes if behaviors are present and chat in progress notes the behavior observed and any non-pharmacological interventions prior to use of any behavioral medications. Document 'N' if no behaviors observed or reported every shift. Review of the Medication Administration Record for 04/2023 revealed nurses initialed behavior monitoring, though failed to identify whether the resident had behaviors. Review of the Consulting Pharmacist Monthly Medication review revealed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/28/23, Antidepressant Gradual Dose Reduction (GDR) attempt reduction of Bupropion XL 100 mg by mouth (PO) twice a day (BID). Physician replied on 02/07/23 with: The resident's target symptoms returned or worsened after previous attempts as GDR. Observation and interview on 04/25/23 at 08:53 AM revealed the resident propelled in her electric chair towards her room. The resident looked tired and when asked stated she did not sleep well due to pain in her feet and legs. She stated she had neuropathy and wounds on her feet and legs starting in another facility from a brown spider bite. Observation on 05/01/23 at 11:30 AM revealed the resident slowly propelling her chair through the hall. The resident smiled a little when greeted and her feet were wrapped per usual. On 05/01/23 at 11:30 AM Licensed Nurse X reported the resident came to the facility last summer with the wounds and received the Hydroxyzine before dressing changes to help with her anxiety. The nurse was unaware of the 14 day stop date for the medication. Nurse X did not know the resident's behaviors were not charted the correct way. The facility's Behavioral Assessment, Intervention and Monitoring policy dated 03/2019 documents that behavioral symptoms would be identified using facility-approved behavioral screening tools. Further that staff documentation would include monitoring of efficacy and adverse consequences. Additionally documents that if a resident is being treated for altered behavior that staff would document any improvements or worsening of target behavior, mood and/or function. The facility failed to ensure R25 was free of unnecessary medications by the failure to ensure the resident was free of unnecessary medications by the failure to consistently monitor/document resident behaviors related to psychotropic medications. - Resident (R)48's signed Physician Orders dated 04/05/23 revealed diagnoses: unspecified dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident had no documented behaviors. The resident required extensive to limited assistance of one staff with daily cares. The resident received pain medication on schedule for pain rated at 8 out of10. R48's medications included antianxiety, antidepressant, anticoagulant, and opioid pain medication. The Physician Orders dated 04/05/23 revealed: 04/05/23: Tramadol HCl Oral Tablet (pain medication) 50 milligrams (MG), Give 1 tablet by mouth (PO) every 12 hours, as needed for pain. 04/05/23: Trazodone HCl Oral Tablet 50 mg, Give 1 tablet PO, at bedtime for insomnia. 04/05/23: Norco Oral Tablet (opioid pain medication)7.5-325 mg (Hydrocodone-Acetaminophen), give 1 tablet PO, four times a day, for pain. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/05/23: Buspirone HCl Oral Tablet 10 mg, give 1 tablet PO, three times, a day for anxiety. 04/05/23: Lexapro Oral Tablet 20 mg, give 1 tablet PO, at bedtime for depression. Anti-Depressant medication: Observe resident closely for significant side effects as follows: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity, excessive weight gain. Document 'N' if none observed. Document 'Y' and chart findings under progress notes, Every shift. Behavior monitoring: Document 'Y' for yes if behaviors are present and chat in progress notes the behavior observed and any non-pharmacological interventions prior to use of any behavioral medications. Document 'N' if no behaviors observed or reported. Every shift 07/28/22, Antidepressant gradual dose reduction (GDR) attempt for Escitalopram 20 mg day and Trazadone 150 mg bedtime (HS). The 08/09/22 Physician response: Escitalopram do not reduce- target symptoms returned or worsened after previous attempt. Decrease Trazadone to 100 mg PO HS. 04/25/23 at 01:16 PM the resident worked with the therapist and used a trapeze bar to sit up and transfer himself to his wheelchair. The resident was pleasant and visited with the therapist during cares and no anxiety noted with the session. On 04/26/23 at 03:50 PM Certified Nurse Aide (CNA) K reported the resident had some pain but not that often. He needed assistance of two to transfer from his bed to his chair or to his toilet. He had no bad behaviors, he would just call out loudly for staff, rather than use his call light for help. On 05/01/23 at 11:30 AM Licensed Nurse X reported the resident was non-compliant. He would cooperate with care without behaviors. We monitor behaviors and side effects for the resident every shift. She did not know the monitoring was not put back on the medication administration record when the resident returned from the hospital on 04/05/23. The facility's Behavioral Assessment, Intervention and Monitoring policy dated 03/2019 documents that behavioral symptoms would be identified using facility-approved behavioral screening tools. Further that staff documentation would include monitoring of efficacy and adverse consequences. Additionally documents that if a resident is being treated for altered behavior that staff would document any improvements or worsening of target behavior, mood and/or function. The facility failed to ensure R48 was free of unnecessary medications by the failure to consistently monitor/document resident behaviors related to psychotropic medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31078 The facility reported a census of 70 residents. The facility identified three residents that received pureed meals from the main kitchen. Based on observation, interview, and record review, the facility failed to prepare and serve food in a sanitary manner to prevent the spread of food borne illnesses to the residents of the facility. Findings included: - On 04/26/23 at 11:00 AM, observation revealed Dietary Staff J pureed food for the noon meal. He brought five slices of ham over to the preparation area with no gloves on, and sliced the ham into small pieces. Without donning gloves, dietary staff J placed the cutting blade into the food chopper. He then donned on gloves and placed the ham into the food chopper, pureed the food, covered with foil and placed the pan of ham into the oven. He gathered his chopping equipment and placed the utensils in the dishwasher. Dietary staff J donned another pair of gloves and assembled the chopper. While wearing the same gloves, he opened the package of bread, reached into the package, and retrieved five pieces of bread and put into the chopper. Review of the undated facility policy called Glove Usage revealed It was the facilities policy to require kitchen staff to be educated on proper glove usage including how to properly put on gloves, activities where gloves are required, when to change gloves and how to properly remove gloves. The facility failed to serve food in a sanitary manner by the failure to change gloves while preparing ready to eat food items and handling equipment with bare hands then placing food items on the equipment to three residents that received pureed diets.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46960 The facility reported a census of 70 residents. Based on observation, interview, and record review the facility failed to provide administrative services in a manner to effectively and efficiently use resources to attain/maintain each resident's highest physical, mental, and psychosocial well-being, for all 70 residents that resided in the facility. Findings include: - Upon annual health resurvey occurring on 04/24/23 to 04/27/23 and 05/01/23 to 05/02/23, the following deficient practices were found which demonstrate the lack of administrative services to effectively and efficiently use resources to attain/maintain each resident's highest physical, mental, and psychosocial well-being: The facility failed to protect the privacy and dignity of Resident (R)52 and R42. This deficient practice led to R42 being able to be around multiple other residents with visibly soiled clothing and R52 living in a malodorous environment. (See F550) The facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in resident areas for the residents of the facility. (See F584) The facility failed to provide a safe and secure living environment for the residents of the facility with the failure to accurately investigate, assess, and implement adequate immediate interventions to prevent the continued abuse of resident-to-residents, following these 14 incidents reviewed. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. (See F600) The facility failed to provide a safe and secure living environment for the residents of the facility with the failure to report the incidents in a timely manner as required, following 11 of these 14 incidents reviewed. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. (See F609) The facility failed to conduct a thorough investigation of the allegations of resident-to-resident abuse and failed to take appropriate corrective actions to protect residents from further abuse. This deficient practice put 70 residents in immediate jeopardy and placed 19 residents at risk for continued resident-to-resident abuse. (See F610) The facility failed to incorporate the recommendations from a Preadmission Screening and Resident Review (PASRR) level II evaluation report into R12's assessment, care plan, and/or a transition of care. (See F644) The facility failed to inform the state mental health authority in a timely manner of R12's significant change on 10/14/22. (See F646) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to develop a comprehensive care plan for one resident of 18 residents reviewed for care plans. R216. (See F656) The facility failed to provide timely care to skilled R216, who was in rehabilitation, with plans to return home. (See F676) The facility failed to ensure staff provided adequate supervision and followed the resident's fall prevention interventions to prevent further falls for R18, including one fall which resulted in a fractured (broken bone) right femur (thigh bone) and surgical repair. (See F689) The facility failed to provide appropriate treatment and services of personal hygiene needs with incontinence for R42 when staff failed to recognize visibly soiled clothing related to urinary incontinence prior to going into the dining room. This deficient practice had the potential to negatively affect R42. (See F690) The facility failed to monitor the use of bed side rails for R4. This deficient practice placed R4 and the other 10 residents at risk for potentially serious injury. (See F700) The facility failed to ensure R54, R43, and R25 were seen by the physician within the required time frame. This had the potential for unrealized changes in the residents' conditions leading to unnecessary complications in their wellbeing. (See F712) The facility failed on four days to have Registered Nurse (RN) coverage for at least eight hours daily in the last three months. (See F727) The facility failed to ensure Certified Nurse Aides (CNA) received an annual evaluation for three of five staff reviewed to ensure the care provided to the residents for their highest practicable level of well-being. (See F730) The facility failed to ensure sufficient competent staffing to address the behavior health needs of the residents to provide a safe environment. (See F741) The facility failed to follow physician's orders for R50 related to insulin not being administered as the physician ordered. This placed the resident at risk for adverse effects related to medication use. (See F755) The facility failed to ensure the residents were free of unnecessary medications by the failure to follow-up timely on pharmacy consultant recommendations for R25, R48, R50, and R57. These failures placed the residents at risk for adverse effects related to medication use. (See F756) The facility failed to ensure R50 and R57 were monitored for side effects of extrapyramidal (abnormal involuntary body movements caused by medications) symptoms due to antipsychotic (a class of medication used to treat psychosis and other mental emotional conditions) medication use, failed to monitor R50 and R48 for behaviors related to antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication use and antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension). (See F758) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility reported a census of 70 residents. The facility failed to prepare and serve food in a sanitary manner to prevent the spread of food borne illnesses to the residents of the facility. (See F812) The facility failed to conduct Quality Assurance and Performance Improvement (QAPI) committee meetings with the required members present, which included having the Medical Director present at the meetings. This had the potential to affect all residents. (See F868) The facility failed to maintain an effective infection control program with the failure of staff to perform hand hygiene when appropriate and failure of the staff to clean equipment between resident use. This deficient practice has the potential to negatively affect every resident in the facility. (See F880) Upon entrance on 04/24/23 at 09:00 AM, Administrative Staff A informed the survey team the facility Director of Nursing (DON) quit two weeks ago, but the Minimum Data Set MDS nurse would be the interim DON. The facility's Staffing policy, dated 10/2017, lacked documentation related to minimum staffing levels or administrative responsibilities. The facility failed to provide administrative services in a manner to effectively and efficiently use resources to attain/maintain each resident's highest physical, mental, and psychosocial well-being, for all 70 residents that resided in the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 41302 The facility reported a census of 70 residents. Based on record review and interview, the facility failed to conduct Quality Assurance and Performance Improvement (QAPI) committee meetings with the required members present, which included having the Medical Director present at the meetings. This had the potential to affect all residents. Findings included: - On 04/24/23 at 01:21 PM, Administrative Staff A provided sign-in sheets for quarterly QAPI meetings from November 2021 through March 2023. The facility lacked documentation for the required members at the meetings, with the Medical Director present at only in December 2021, February 2022, March 2022, and July 2022. On 04/27/23 at 03:44 PM, Administrative Staff A confirmed the facility failed to ensure the Medical Director attended required quarterly QAPI meetings The facility's Quality Assessment Assurance (QAA) Plan policy dated 11/08/22, documented that the administrator, the director of nursing, infection preventionist, and at least two other staff members must attend each meeting. The medical director shall always be a part of QAPI efforts and must attend a meeting at least quarterly. The facility failed to conduct quarterly Quality Assurance and Performance Improvement (QAPI) committee meetings with the required members present, which included the medical director .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46960 The facility reported a census of 70 residents. Based on observation, interview and record review, the facility failed to maintain an effective infection control program with the failure of staff to perform hand hygiene when appropriate and failure of the staff to clean equipment between resident use. This deficient practice has the potential to negatively affect every resident in the facility. Findings include: - On 04/24/23 at 02:30 PM in the special care unit, Certified Nurse Aide (CNA) O carried her personal non-disposable cup and walked into a resident room to perform cares and came out of the room carrying a clear plastic bag that contained items with an unknown brown substance visible through the bag, in the same hand as her personal non-disposable cup. CNA O walked to the soiled utility room to dispose of the bag. CNA O continued to carry her personal non-disposable cup and went to perform cares on another resident then returned to the hallway without hand hygiene observed. On 04/24/23 at 02:45 PM, CNA O stated she performed hand hygiene inside the soiled utility room with alcohol-based hand rub before she provided cares to other residents. CNA O stated she did not clean her cup from the potential contaminates and stated that personal non-disposable cups should not be taken into resident rooms. On 04/24/23 at 02:48 PM Administrative Nurse P stated no personal items from staff should be carried from resident to resident room, as it presents an infection control risk for cross-contamination. On 04/25/23 at 07:54 AM, Laundry Staff Q observed to deliver clean laundry to a resident room and manipulated the hallway door and closet door. Laundry Staff Q then picked up another resident's clean laundry from the laundry cart in the hallway and delivered to a different resident's room and manipulated the hallway door and closet door. Laundry Staff Q's hand hygiene not observed between contacts. Laundry Staff Q also observed taking two individual resident's clean laundry in to one resident's room and then into the second resident's room. On 04/25/23 at 08:00 AM, Laundry Staff Q stated she did not perform hand hygiene between resident rooms. On 04/25/23 at 08:05 AM Housekeeping G stated every staff member was required to utilize some form of hand hygiene before entering and after exiting resident rooms. Furthermore, stated that resident's laundry was supposed to be delivered one resident at a time to prevent cross contamination between rooms. On 04/26/23 at 08:15 AM Transportation Staff T delivered a resident's meal tray to his room. The resident was utilizing his urinal upon her entry to the room. The resident completed his task and handed the urinal to Transportation Staff T. Transportation Staff T then took his urinal and placed it on the bedside table and continued to set up resident's breakfast tray and put jelly on the resident's muffin. No hand hygiene observed between staff's contact with resident's urinal and staff's contact with the resident's food. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/26/23 at 10:57 AM, CNA L and CNA D exited a resident's room with a full body mechanical lift (a device used to transfer a person who is unable or incapable of sitting or standing). CNA L moved the mechanical lift outside of the special care unit doors and left the mechanical lift in the hallway then re-entered the special care unit without having sanitized the mechanical lift. On 04/26/23 at 11:00 AM CNA L and CNA D revealed that they did not sanitize the mechanical lift before exiting the resident's room. CNA L stated that lifts were supposed to be cleaned weekly. On 04/26/23 at 11:05 AM Administrative Nurse P stated that mechanical lifts were supposed to be cleaned weekly and as needed. She went on to say that mechanical lifts are supposed to be sanitized before and after each resident's use. Additionally, Administrative Nurse P stated all staff were expected to perform hand hygiene before entering a resident's room and after exiting a resident's room, regardless of the staff member's reason for entering a resident's room. The facility's undated Handwashing and Hand Hygiene Policy documented that all personnel were trained and regularly in-serviced on the importance of hand hygiene. Further directed staff to perform hand hygiene with soap and water or alcohol-based hand rub after contact with objects in the immediate vicinity of a resident. Additionally, directed staff to perform hand hygiene before and after eating or handling food as well as before and after assisting a resident with meals. The facility failed to maintain an effective infection control program with the failure of staff to perform hand hygiene when appropriate and failure of the staff to clean equipment between resident use.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 70 residents. Based on observation and interviews, the facility failed to maintain an adequate call light system for the residents of the facility, when only two direct care workers had access to pagers to monitor for call lights, on the facility five resident hallways. Findings included: - On 05/01/23 at 03:00 PM, observation in the one hall nurses station, revealed the only facility monitor screen for the call light system in the facility. The monitor on the wall documented, Green, Unknown, Zone 45; Concord East- Main low battery failure; Concord West-Main low battery failure; and room [ROOM NUMBER] bed 2 resident, Repeated 6 times. At that time, Maintenance Staff Z reported no knowledge of the call light documentation or where Zone 45 would be. Staff Z referred the question to Administrative Staff A. Staff A reported she had to come to the facility recently (unknown date) to reset the system as it had Froze and those had been on the monitor since that time. Staff A continued to explain the call light system per request and reported the direct care staff and medication staff should carry pagers so they would not need to be in the nurses station to monitor residents call lights. She explained hallways 100 and 300 currently shared 2 staff. At that time questioning of Certified Nurse Aide CNA K for those hallways had no pager on her person. Staff A explained the second person for these halls would be in at a later time to assist CN A K on the hallways and that Licensed Nurse LN P was currently helping to watch the hallways and passing medications. LN P at that time, verified she had no pager on her person. Staff A continued and reported that CNAs BB and CC were responsible for hallways 200 and 400. Verification with the staff at that time revealed CNA BB did carry a pager and CNA CC did not. When questioning of CNA CC for how she monitored the resident call lights without a pager, she stated she would just run back and forth. Staff A explained the facility had problems with keeping the pagers and they would disappear as staff would take them home when they left and not return them. She explained she had someone running after a staff member now that had taken one with them when they left. She did verify the facility only currently had 2 pagers in the building at this time. When asked of Staff A who monitored for the call light system on the 400 or special care unit hallway, she stated those residents were not able to use call lights so they did not need to monitor that hallway. At that time, Staff A walked down the special care unit hallway, and went into room [ROOM NUMBER]. The call light was turned on at 03:24 PM, and it did light at the wall. Staff A then per invitation, sat on a bench in the hallway across from room [ROOM NUMBER]. At 03:28 PM, LN P entered the special care unit walking up and down the hallway looking at rooms. LN P finally asked where room [ROOM NUMBER] was as she carried one of the pagers and the 400 hallway had no room numbers as 412. Further observations revealed multiple different staff walked up and down the hallway, in and out of room [ROOM NUMBER] and never noticed the call light on the wall was lite. The facility failed to maintain an adequate call light system for the residents of the facility, when only two direct care workers had access to pagers to monitor for call lights, on the facility five resident hallways.