STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175172	A. Building B. Wing	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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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 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. 27168 The facility had a census of 106 residents. The sample included 28 residents. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and respect, when staff had Resident (R)32's physician ordered medication lists visible on the unattended computer screen on the North Hall, and failed to promote dignity for R10 when staff checked R10's blood sugar (test measures the concentration of glucose/sugar in the blood) and administered their insulin (a medication used to regulate blood sugar levels) at the dining room table in the South Hall with two other residents able to view during meal service. Findings included: - On 11/07/22 at 9:30 AM, observation revealed during initial tour the North Hall computer on the medication cart screen was left open and the screen visible with R32's name and medication orders pulled up on the screen. Continued observation revealed the cart was left unattended for approximately 5 minutes with two residents and one staff walking by the computer with the resident's information visible. On 11/15/22 at 10:30 AM, Administrative Nurse D verified staff should not leave the computer screen open on the medication cart computer with the resident's name and medication visible on the screen for residents, visitors, and staff to see. The facility's Quality of Life and Dignity, policy dated 10/2021, recorded each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents should be treated with dignity and respect at all times. Staff shall maintain an environment in which confidential clinical information is protected. The facility failed to promote care for R32 in a manner to maintain and enhance dignity and respect. 32358 - On 11/15/22 at 12:49 PM, observation revealed in the 100-hall small dining room Licensed Nurse (LN) J took R10's blood sugar test (a procedure using a machine to take a sample of blood to measure the amount of sugar) and administered her insulin (a medication used to regulate blood sugar levels) in her abdomen at the dining room table with R88 and R94 able to view the procedures. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/15/22 at 12:49 PM, LN J stated if she caught R10 in her room she would check her blood sugar and administer R10's insulin there, but once R10 was in the dining room she did not want to leave so she did the procedures in the dining room. LN J stated three residents were diabetic. On 11/15/22 at 02:00 PM, Administrative Nurse D stated she would expect staff to check R10's blood sugar and administer her insulin in a private area of the facility. The facility's Quality of Life/Dignity Policy, revised 10/21, documented each resident should be cared for in a manner that promotes and enhances quality of life, dignity, and individuality. The facility failed to treat R10 with dignity when staff checked her blood sugar and administered her insulin in her abdomen at the dining room table with two other residents able to view. This placed the resident at risk for an undignified experience.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 26768 The facility had a census of 106 residents. Based on observation, interview, and record review the facility failed to provide adequate housekeeping and maintenance services to ensure a safe, clean, comfortable, homelike environment for Residents (R)5, R32, R56, R19, R18 on four of six halls of the facility. This deficient practice placed residents at risk for a less than pleasant homelike environment. Findings included: - On 11/07/22 at 11:24 AM, observation in R5's room revealed scraped wall paint behind the headboards and dirty linens on the floor between R5's bed and her roommate's bed. On 11/07/22 at 04:00 PM, observation revealed the following: R32's room had gray stains on the ceiling above bed A, and a second ceiling stain in the middle of the room, both approximately twelve inches by six inches. R56's room had four ceiling tiles with stains. R19's room, both A and B beds had missing wall mop board under the head of the bed with insulation and wall studs visible. R18's room had paint scratched off the bathroom door, from the floor approximately 24 inches up, with chips of paint missing. On 11/15/22 at 11:08 AM, during a tour of the facility Maintenance Staff U verified the above findings. He stated the facility had replaced the roof August 2021 and the facility had ceiling tiles in storage, but he had not gotten the damaged ones changed yet. Maintenance Staff U stated staff were to inform him of needed repairs through the facility's messaging system. He verified staff had not reported the missing or damaged mopboard in R19's room and that damage was something that required immediate attention. Upon request the facility did not provide a policy for housekeeping or maintenance of the building. The facility failed to provide adequate housekeeping and maintenance services to ensure a safe, clean, comfortable, homelike environment for five residents on four of six halls of the facility, placing the residents at risk for a less than pleasant homelike environment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 32360 The facility had a census of 106 residents. The sample included 28 residents. Based on observation, record review, and interview, the facility failed to investigate burns on one resident, Resident (R) 2, who had burns on his index and middle finger of his right hand. This place the resident at risk for further injury. Findings included: - The Electronic Medical Record (EMR) for R2 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory), seizures (a sudden, uncontrolled electrical disturbance in the brain), and heart failure (a chronic condition in which the heart does not pump blood as well as it should). The 10/27/22 Quarterly Minimum Data Set (MDS) documented R2 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, and extensive assistance of one staff for eating. The MDS further documented R2 had unsteady balance and lower functional impairment on both sides. The 07/29/22 Hot Liquids Safety Evaluation documented R2 demonstrated the ability to handle eating equipment with no risk. The 10/28/22 Care Plan, initiated on 01/25/22, directed staff to assist R2 to hold his cup and provide one or more sips of liquid at any time, or lift the resident's hand to his mouth while the resident held a utensil or cup. The update, dated 08/25/22, directed staff to use coffee lids to coffee cups with hot liquids. The update, dated 11/06/22, directed staff to have R2 use his personal beverage cup with a lid or the facility cup with a lid for cold and hot liquids. The Nurse's Note, dated 10/14/22 at 01:05 PM, documented R2 had open areas to his right index and middle fingers. The nurse's note lacked an investigation as to how R2 obtained the open areas. The Physician's Order, dated 10/14/22, directed staff to cleanse the areas with normal saline and apply Silvadene External Cream 1% (a topical antibiotic cream used to treat burns), to the middle and index finger, everyday shift. and a dry dressing. The Wound Evaluation, dated 10/18/22, documented R2 had a burn on his right middle finger measured 2 centimeters (cm) x 1.5 cm x 0.1 cm and a burn to his right index fingers, which also measured 2 cm x 1.5 cm x 0.1 cm. The Wound Evaluation, dated 10/25/22, documented R2 had a burn on his right middle finger measured 0.6 cm x 0.6 cm and a burn to his right index finger measured 1.5 cm x 0.8 cm. The Wound Evaluation, dated 11/02/22, documented R2 had a burn on his right middle finger measured 0.5 cm x 0.5 cm and right index finger measured 1.5 cm x 0.6 cm x 0.1 cm. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Note, dated 11/03/22 at 01:39 PM directed staff to cleanse the wounds on his index and middle finger with saline. Use the saline to scrub or irrigate the wound bed, paint skin protectant over the area of stable eschar (dead tissue). The note further directed staff to ensure the edges and surrounding skin were painted everyday shift, until resolved. The 11/08/22 Nurse's Note documented R2's wounds were resolved. The undated Investigation documented R2 had ongoing open areas to his right-hand fingers and lacked substantial evidence that the areas were a result of burns. The investigation further documented; staff would be educated on diagnosis of blisters without substantial evidence of injury. The investigation was not signed or dated by administrative staff. On 11/07/22 at 12:05 AM, observation revealed R2 ate in the dining room. Further observation revealed R2's right hand shook as he drank his water and did not have any hot liquids. On 11/08/22 at 09:00 AM, observation revealed on the inside of R2's right hand index and middle finger exhibited abnormal, pinkened areas, approximately 0.5 cm in size. On 11/14/22 at 11:17 AM, Licensed Nurse (LN) G stated R2 asked a nurse aide to take him outside to smoke and that he had burned his fingers. LN G further stated that the resident had not smoked for a long time and because of his dementia, he did not remember that he had not smoked. LN G stated the agency nurse aide did not look at the smoking list when she took him outside. On 11/14/22 at 01:45 PM, Administrative Nurse D stated the areas on his fingers were not from a burn, but because of his arthritis in his hands, the coffee cup handle rubbed the areas on his fingers. Administrative Nurse D stated she did not know why staff said the areas were from a cigarette burn. On 11/15/22 at 08:50 AM, Consultant GG stated when he looked at the wounds, they looked like burns and he ordered Silvadene Cream for the wounds. On 11/15/22 at 10:47 AM, LN I stated the burns on the resident's fingers were from coffee he spilt and that was why they have lids on his coffee cup. On 11/15/22 at 03:00 PM, Administrative Nurse D stated she had not completed an investigation after the wounds were found on R2's fingers (10/14/22) and that she did the investigation paperwork on 11/14/22 (a month later). Administrative Nurse D further stated she did not know how the resident received the burns on his fingers. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse policy, dated 02/19/2022, documented the facility prohibits the mistreatment neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, friends, family. The policy further documented allegations/report of suspected abuse, neglect, mistreatment distortion injury of unknown etiology or misappropriation shall be promptly and thoroughly investigated by facility management. The shift supervisor/charge nurse was identified as responsible for immediate initiation of the reporting process upon receipt of the allegation, the administrator and director of nursing were responsible for investigation and reporting factual data on the incident entry report. The investigation should be thorough with witness statements from staff, residents, visitors, and family members who may be interview able to have information regarding the allegation. A conclusion must include whether the allegation was substantiated or not and what information supported the decision. The report results of investigation was sent to the proper authorities as required by the state The facility failed to investigation burns on cognitively impaired R2, placing him at risk for further injury.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 106 residents. The sample included 28 residents with 8 residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide necessary services to maintain good personal hygiene, including bathing for six of the eight reviewed for ADLs, Resident (R)8, R22, R32, R2, R5, and R44. This placed the residents at risk for poor personal hygiene and infection. Findings included: - R8's Physician's Order Sheet, dated 11/01/22, recorded diagnoses of cerebral vascular disease with hypoxia (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 ,) dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion,) anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear,) major depressive disorder (major mood disorder.) R8's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had moderately impaired cognition. The MDS recorded R8 required extensive assistance of one staff with toilet use, personal hygiene, and bathing. The ADL Care Plan, dated 10/07/22, recorded R8 directed one staff to assist the resident with shower/bath on Tuesdays and Fridays during the evening shift and provide assistance with hygienic cares. The ADL Care Plan recorded showers were also provided by hospice staff. The electronic health records Bathing Task documented R8 was scheduled for a bath/shower on Tuesdays and Fridays. The September Bath/shower Report and the electronic health records Bathing Task documented R8 received a shower/bath on the following days: 09/13/22 09/21/22 (no shower or bath documented for 7 days) 09/27/22 The October Bath/shower Report and the electronic health records Bathing Task documented R8 received a shower/bath on the following days: 10/04/22 (no shower or bath documented for 6 days) 10/08/22 10/14/22 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The November Bath/shower Report and the electronic health records Bathing Task documented R8 received a shower/bath on the following days: 11/08/22 (no shower or bath documented for 24 days) 11/11/22 On 11/14/22 at 09:00 AM, observation revealed R8 seated in a Broda chair at the dining room table, staff assisted the resident with eating breakfast. Continued observation of the resident revealed R8 dressed in street clothes. On 11/15/22 at 10:30 AM, Administrative Nurse D verified the residents had scheduled bath/shower days and the aides documented in the electronic health records and they had paper shower sheets to document when the resident received a shower/bath. Administrative Nurse D stated if a bath was not documented it was not completed. The facility's Activities of Daily Living policy, dared July 2019, documented it was the policy of this facility to shower residents, to cleanse and refresh the resident, observe the skin, and to provide increased circulation The facility failed to provide the necessary care and bathing services for R8, placing the resident at risk for poor hygiene, and skin breakdown. - R22's Physician's Order Sheet, dated 10/01/22, recorded diagnoses of Diabetes Mellitus Type two (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) end stage renal disease (a terminal disease because of irreversible damage to vital tissues or organs,)dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion,) anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear,) and major depressive disorder (major mood disorder.) R22's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had moderately impaired cognition. The MDS recorded R22 required extensive assistance of one staff with toilet use, personal hygiene, and bathing activity did not occur. The ADL Care Plan, dated 08/23/22, recorded R22 directed one staff to assist the resident assistance with hygienic cares. The ADL Care Plan recorded the resident had the potential to be resistive to cares and yelling at staff and staff to redirect negative behaviors. The electronic health records Bathing task documented R22 was scheduled for a bath/shower on Tuesdays and Fridays. The September Bath/shower Report and the electronic health records Bathing Task documented R22 did not received a shower/bath on the following days: 09/01/22 09/13/22 (no shower or bath documented for 11 days) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/22/22 (no shower or bath documented for 8 days) 09/27/22 The October Bath/shower Report and the electronic health records Bathing task documented R22 received a shower/bath on the following days: 10/06/22 (no shower or bath documented for 8 days) 10/13/22 10/28/22 (no shower or bath documented for 13 days) On 11/08/22 at 08:35 AM, observation revealed R22 seated in a wheelchair at the dining room table eating breakfast. Continued observation of the resident revealed R22 was dressed in stree t clothes On 11/15/22 at 10:30 AM, Administrative Nurse D verified the residents had scheduled bath/shower days and the aides documented in the electronic health records and they had paper shower sheets to document when the resident received a shower/bath. Administrative Nurse D stated if a bath was not documented it was not completed. The facility's Activities of Daily Living policy, dared July 2019, documented it was the policy of this facility to shower residents, to cleanse and refresh the resident, observe the skin, and to provide increased circulation The facility failed to provide the necessary care and bathing services for R22, placing the resident at risk for poor hygiene, and skin breakdown. - 32's Physician's Order Sheet, dated 10/01/22, recorded diagnoses Diabetes Mellites (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) schizophrenia (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin ,)Cerebral Vascular Disease (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 ,) dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion,) anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear,) major depressive disorder (major mood disorder.) R32's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had intact cognition. The MDS recorded R32 required extensive assistance of one staff with toilet use, personal hygiene, and bathing. The ADL Care Plan, dated 10/17/22, recorded R32 directed one staff to assist the resident with shower/bath on Tuesdays and Fridays during the evening shift and provide assistance with hygienic cares. The ADL Care Plan recorded showers were also provided by hospice staff. The electronic health records Bathing Task documented R32 was scheduled for a bath or shower on Wednesday and Saturday evenings. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The September Bath/shower Report and the electronic health records Bathing Task documented R32 received a shower/bath on the following days: 09/08/22 09/14/22 09/21/22 (no shower or bath for 6 days) The October Bath/shower Report and the electronic health records Bathing Task documented R32 received a shower/bath on the following days: 10/13/22 (no shower or bath for 11 days) 10/26/22 (no shower or bath for 13 days) The November Bath/shower Report and the electronic health records Bathing Task documented R32 received a shower/bath on the following days: 11/01/22 11/18/22 (no shower or bath for 6 days) On 11/07/22 at 10:35 AM, observation revealed R32 seated in a wheelchair in the hallway watching staff and residents go up and down the hallways. Continued observation revealed the resident was dressed in street clothes and had grease and uncombed hair. On 11/15/22 at 10:30 AM, Administrative Nurse D verified the residents had scheduled bath/shower days and the aides documented in the electronic health records and they have paper shower sheets when the resident received a shower/bath. Administrative Nurse D stated if a bath was not documented it was not completed. The facility's Activities of Daily Living policy, dared July 2019, documented it was the policy of this facility to shower residents, to cleanse and refresh the resident, observe the skin, and to provide increased circulation The facility failed to provide the necessary care and bathing services for R32, placing the resident at risk for poor hygiene, and skin breakdown. 32360 - The Electronic Medical Record (EMR) for R2 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory), seizures (a sudden, uncontrolled electrical disturbance in the brain), and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, and toileting. The MDS further documented R2 required extensive assistance of one staff for bathing. The ADL Care Plan, dated 10/28/22, documented R2 requested a bath or shower twice a week and as needed, required physical assistance with part of the bathing activity, and Hospice would provide showers along with the facility. The October Bathing Report and Facility Bathing Sheets documented R2 requested showers on Wednesday and Saturday dayshift and documented R2 had not received a bath or shower during the following days: 10/06/22-10/11/22 (6 days) 10/13/22-10/21 (9 days) The EMR lacked documentation R2 refused a shower. The October and November 2022 Bathing Report and Facility Bathing Sheets documented R2 requested showers on Wednesday and Saturday dayshift and documented R2 had not received a bath or a shower during the following days: 10/27/22-11/03/22 (8 days) The EMR documented R2 refused a bath or shower on 10/29/22. On 11/14/22 at 09:25 AM, observation revealed R2's blue shirt had crumbs and wet spots on it. Continued observation at 11:07 AM, revealed R2 had on the same blue shirt and the wet spots had dried, staining his shirt. On 11/15/22 at 09:17 AM, observation revealed R2, unshaven, and his gray sweatpants and shirts had debris from breakfast and his shirt was stained. Further observation revealed R2 had dried food along the left side of his mouth. On 11/15/22 at 09:24 AM, Certified Nurse Aide O stated R2 did not usually refuse his showers, but she was agency and was not at the facility all the time. CNA O further stated, they document showers in the computer and on bathing sheets and if a resident refused, she told the charge nurse. On 11/15/22 at 10:00 AM, Licensed Nurse (LN) G stated if a resident refused his shower, the bath sheets were given to the charge nurse and the nurse would talk with the resident. If the resident still refused, the unit manager would talk with the resident to change days and times for the shower. On 11/15/22 at 03:00 PM, Administrative Nurse D stated residents should receive showers per their care plan. The facility's ADL-Bath Shower policy, dated July 2019, documented the facility showered residents to cleanse and refresh the resident, observe the skin, and the shower provided increased circulation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide R2 bathing services, placing the resident at risk for poor hygiene. - The Electronic Medical Record (EMR) for R5 documented diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). R5's Admission Minimum Data Set (MDS), dated [DATE], documented R5 had intact cognition and required supervision and setup help only for bed mobility, transfers, dressing, and personal hygiene. The MDS further documented R5 required limited assistance of one staff for bathing. The Care Plan, dated 10/13/22, documented R5 requested a shower or bath on Tuesday and Friday and required assistance with activities of daily living. The October 2022 Bathing Report and Facility Bathing Sheets documented R5 requested showers on Wednesday and Saturday dayshift and lacked documentation R5 received the requested two showers per week. On 11/08/22 at 08:16 AM, observation revealed R5 in her room, hair disheveled, and not feeling well. On 11/15/22 at 09:00 AM, Certified Nurse Aide (CNA) O stated she gave resident's showers from a list she was given and did not think R5 refused any showers. On 11/15/22 at 10:00 AM, Licensed Nurse (LN) G stated if a resident refused his or her shower, the bath sheets were given to the charge nurse and the nurse would talk with the resident. If the resident still refused, the unit manager would talk with the resident to change days and times for the shower. On 11/15/22 at 03:00 PM, Administrative Nurse D stated residents should receive showers per their care plan. The facility's ADL-Bath Shower policy, dated July 2019, documented the facility showered residents to cleanse and refresh the resident, observe the skin, and the shower provided increased circulation. The facility failed to provide R5 bathing services as care planned, placing the resident at risk for poor hygiene. - The Electronic Medical Record (EMR) for R44 documented diagnoses of spina bifida (a congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the back bone), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), hypertension (high blood pressure), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS), dated [DATE], documented R44 had moderately impaired cognition and dependent upon two staff for transfers, dressing, toileting, and bathing. The Care Plan, dated 10/18/22, directed staff to assist R44 with all cares and to provide the resident with a shower or bath on Tuesday and Friday during the dayshift. The September 2022 Bathing Report and Facility Bathing Sheets documented R44 requested showers on Wednesday and Saturday dayshift and documented R44 had not received a bath or shower during the following days: 09/03/22-09/19/22 (17 days) The September and October 2022 Bathing Report and Facility Bathing Sheets documented R2 requested showers on Wednesday and Saturday dayshift and documented R44 had not received a bath or shower during the following days: 09/28/22-10/09/22 (7 days) On 11/08/22 at 09:21 AM, observation revealed R44 had food debris on his face, stains on his shirt, and food debris on his shirt and pants. On 11/15/22 at 09:00 AM, Certified Nurse Aide (CNA) O stated she gave resident's showers from a list she was given and did not think R44 refused any showers. On 11/15/22 at 10:00 AM, Licensed Nurse (LN) G stated if a resident refused his or her shower, the bath sheets were given to the charge nurse and the nurse would talk with the resident. If the resident still refused, the unit manager would talk with the resident to change days and times for the shower. On 11/15/22 at 03:00 PM, Administrative Nurse D stated residents should receive showers per their care plan. The facility's ADL-Bath Shower policy, dated July 2019, documented the facility showered residents to cleanse and refresh the resident, observe the skin, and the shower provided increased circulation. The facility failed to provide R44 bathing services as care planned, placing the resident at risk for poor hygiene.

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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. 32360 The facility had a census of 106 residents. The sample included 28 residents, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents and failed to identify causative factors to prevent future injuries for Resident (R) 2, which resulted in burns to his fingers. The facility further failed to ensure an environment as free of hazards as possible when the facility stored chemicals in an unsecured area accessible to residents. This placed the residents at risk for further accidents. Findings included: - The Electronic Medical Record (EMR) for R2 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory), seizures (a sudden, uncontrolled electrical disturbance in the brain), and heart failure (a chronic condition in which the heart does not pump blood as well as it should). The 10/27/22 Quarterly Minimum Data Set (MDS) documented R2 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, and extensive assistance of one staff for eating. The MDS further documented R2 had unsteady balance and lower functional impairment on both sides. The 07/29/22 Hot Liquids Safety Evaluation documented R2 demonstrated the ability to handle eating equipment with no risk. The 10/28/22 Care Plan, initiated on 01/25/22, directed staff to assist R2 to hold his cup and provide one or more sips of liquid at any time, or lift the resident's hand to his mouth while the resident held a utensil or cup. The update, dated 08/25/22, directed staff to use coffee lids to coffee cups with hot liquids. The update, dated 11/06/22, directed staff to have R2 use his personal beverage cup with a lid or the facility cup with a lid for cold and hot liquids. The Nurse's Note, dated 10/14/22 at 01:05 PM, documented R2 had open areas to his right index and middle fingers. The nurse's note lacked an investigation as to how R2 obtained the open areas. The Physician's Order, dated 10/14/22, directed staff to cleanse the areas with normal saline and apply Silvadene External Cream 1% (a topical antibiotic cream used to treat burns), to the middle and index finger, every day shift. and a dry dressing. The Wound Evaluation, dated 10/18/22, documented R2 had a burn on his right middle finger which measured 2 centimeters (cm) x 1.5 cm x 0.1 cm and a burn to his right index fingers, which also measured 2 cm x 1.5 cm x 0.1 cm. The Wound Evaluation, dated 10/25/22, documented R2 had a burn on his right middle finger measured 0.6 cm x 0.6 cm and a burn to his right index finger measured 1.5 cm x 0.8 cm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Wound Evaluation, dated 11/02/22, documented R2 had a burn on his right middle finger measured 0.5 cm x 0.5 cm and right index finger measured 1.5 cm x 0.6 cm x 0.1 cm. The Medication Administration Note, dated 11/03/22 at 01:39 PM directed staff to cleanse the wounds on his index and middle finger with saline. Use the saline to scrub or irrigate the wound bed, paint skin protectant over the area of stable eschar (dead tissue). The note further directed staff to ensure the edges and surrounding skin were painted every day shift, until resolved. The 11/08/22 Nurse's Note documented R2's wounds were resolved. The undated Investigation documented R2 had ongoing open areas to his right-hand fingers and lacked substantial evidence that the areas were a result of burns. The investigation further documented; staff would be educated on diagnosis of blisters without substantial evidence of injury. The investigation was not signed or dated by administrative staff. On 11/07/22 at 12:05 AM, observation revealed R2 ate in the dining room. Further observation revealed R2's right hand shook as he drank his water and did not have any hot liquids. On 11/08/22 at 09:00 AM, observation revealed on the inside of R2's right hand index and middle finger exhibited abnormal, pinkened areas, approximately 0.5 cm in size. On 11/14/22 at 11:17 AM, Licensed Nurse (LN) G stated R2 asked a nurse aide to take him outside to smoke and that he had burned his fingers. LN G further stated that the resident had not smoked for a long time and because of his dementia, he did not remember that he had not smoked. LN G stated the agency nurse aide did not look at the smoking list when she took him outside. On 11/14/22 at 01:45 PM, Administrative Nurse D stated the areas on his fingers were not from a burn, but because of his arthritis in his hands, the coffee cup handle rubbed the areas on his fingers. Administrative Nurse D stated she did not know why staff said the areas were from a cigarette burn. On 11/15/22 at 08:50 AM, Consultant GG stated when he looked at the wounds, they looked like burns and he ordered Silvadene Cream for the wounds. On 11/15/22 at 10:47 AM, LN I stated the burns on the resident's fingers were from coffee he spillled and that was why they have lids on his coffee cup. On 11/15/22 at 03:00 PM, Administrative Nurse D stated she had not completed an investigation after the wounds were found on R2's fingers (10/14/22) and that she did the investigation paperwork on 11/14/22 (a month later). Administrative Nurse D further stated she did not know how the resident received the burns on his fingers. The facility did not provide a policy regarding accidents and incidents as requested. The facility failed to provide adequate supervision and identify potential causative factors to prevent future accidents for cognitively impaired R2. As a result, R2 sustained burn injuries to his fingers. 27168 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- On 11/07/22 at 11:20 AM, observation during initial facility tour revealed an unlocked shower room door on the North Hall. Further observation revealed the door contained a keypad to open the door and the thumb turned knob on the back side of the door was turned to the unlock at all times. The soiled utility room contained the following: in an unlocked four door wooden cabinet: 3 - 160 count cannister of Medline Micro Kill Germicidal wipes 160 count - with the warning keep out of reach of children, causes serious eye irritation May cause respiratory issues, highly flammable. 3 - 150 count cannisters of Micro Kill Bleach wipes - with the warning keep out of reach of children, causes serious eye irritation May cause respiratory issues, highly flammable. 2 -One-gallon spray of ACS Tornadol 1 one step disinfectant, with the warning Keep out of reach of children 2- One-gallon spray bottles of ACS Lemon Disinfectant bottles - with the warning keep out of reach of children Chemicals storage in a plastic two door wall mount cabinet above the sink contained the following: 1 - 32-ounce container of Microban 24-hour bathroom disinfectant spray, with the warning keep out of reach of children. On 11/07/22 at 11:35 AM, Licensed Nurse (LN) GG verified the chemicals in the unlocked soiled utility room, stated the shower room door should have been locked, and chemicals were to be stored in a locked secure location. On 11/15/22 at 10:20 AM, Administrative Nurse D verified the shower room door was to remain locked at all times and chemicals needed to be kept behind a locked door. Administrative Nurse D stated the facility had three cognitively impaired independently mobile residents. Upon request the facility lacked a chemical storage policy. The facility failed to store hazardous chemicals in a safe environment, placing the three cognitively impaired independently mobile residents on the North Hall at risk for injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 106 residents. The sample included 28 residents. Based on observation, record review, and interview the facility failed to provide timely incontinent cares for two of five residents reviewed for incontinence Resident (R)1 and R2. This placed the residents at risk for skin breakdown and impaired dignity and comfort. - Resident (R)1's Electronic Medical Record (EMR) documented the resident had a diagnosis of reduced mobility and irritable bowel syndrome (abnormally increased motility of the small and large intestines) with diarrhea, R1's Significant Change Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R1required extensive staff assistance with activities of daily living (ADLs), was frequently incontinent of urine, and always incontinent of bowel. R1's Urinary Incontinence Care Area Assessment (CAA), dated 09/23/22, documented he had a history of stroke (when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients) and required extensive staff assistance with toileting, and was incontinent of bowel and bladder. R1's ADL Care Plan, dated 09/24/22, documented he required extensive staff assistance with toilet use and limited staff assistance with personal hygiene. R1's Bladder/Bowel Incontinence Care Plan, dated 09/24/22, documented he had an overactive bladder, used incontinence briefs, and instructed staff to monitor/document/report to physician any changes in incontinence. The care plan instructed staff to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets as needed. On 11/10/22 at 02:00 PM, observation revealed Certified Nurse Aide (CNA) OO and PP provided R1 incontinent cares. CNA OO applied gloves, unfastened and removed R1's saturated incontinent brief with urine, his pants, and bed pad underneath the resident were wet. CNA OO verified R1's pants and bed pad were wet with urine. On 11/15/22 01:39 PM, Administrative Nurse D stated she would expect staff to change the R1's incontinent brief before his incontinent brief became saturated. The facility's Incontinence-Urine-Assessment and Management Policy, revised 05/19, documented a check and change strategy involved checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals were to maintain dignity and comfort and to protect the skin. The facility staff failed to provide timely incontinent care for R1, when his incontinent brief was saturated, and pants and bed pad were wet with urine. This placed R1 at risk for skin breakdown and impaired dignity and comfort. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32360 - The Electronic Medical Record (EMR) for R2 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory), seizures (a sudden, uncontrolled electrical disturbance in the brain), and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, and toileting. The MDS further documented R2 always incontinent of bowel and bladder and was not on a toileting plan. The Determination of A Bladder Program, dated 08/26/22, documented R2 was oriented to person, could not follow instructions, unaware when voiding, unable to control passing of urine, and no toileting program at this time. The Care Plan, dated 10/28/22, directed staff to apply moisture barrier with incontinence care and as needed, minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets as needed, and observe pattern of incontinence and initiate toileting schedule if indicated. On 11/08/22 at 09:01 AM, observation revealed R2's sweatpants were soiled. Further observation revealed Certified Nurse Aide (CNA) N and CNA M used a mechanical lift to stand R2 to change his incontinence brief. Continued observation revealed R2's wheelchair cushion was wet and the back of the resident's sweatpants were soiled. Observation revealed R2's incontinent brief was heavily soiled with urine. Further observation revealed CNA N changed R2's incontinence brief, did not use barrier cream after peri-care, and put a clean pair of sweatpants on the resident. On 11/08/22 at 09:01 AM, CNA N stated they do not toilet the resident, just check and changed him. CNA N stated R2 was always out of bed when she started her shift at 7:00 AM and he would not be checked until after breakfast. CNA N further stated, he was always saturated and would need his clothing changed. On 11/15/22 ay 03:00 PM, Administrative Nurse D stated R2 should not have to sit in a soiled brief during breakfast and that staff would try different times to check and change the resident. The facility's Incontinence-Urine-Assessment and Management policy, dated May 2019, documented, the check ad Change strategy involved checking the resident's incontinence status at regular intervals and using incontinence devices or garments. The policy further documented the facility's primary goal was to maintain dignity, comfort and to protect the skin. The facility failed to provide incontinence care in a timely manner for cognitively impaired R2, placing the resident at risk for skin breakdown, and impaired dignity and comfort.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census 106 residents. Based on observation, interview, and record review the facility failed to ensure all direct care staff working with residents of the facility had adequate competency assessments. This deficient practice placed the 106 residents of the facility at risk to not have their individual care needs met, and failed to ensure licensed nursing staff possessed the necessary skills, knowledge and awareness to care for a resident who had returned to the facility from the hospital, Resident (R) 5, who had returned the on the previous shift. This placed the resident at risk for unmet needs. Findings included: - Review of facility provided staff information revealed only one Certified Nurse Aide (CNA) hired by the facility had worked here for more than one year. CNA RR, hired 11/01/16, lacked competency assessments for the past year. Review of facility employed contract agency nurse aides revealed the following: CNA SS and CNA NN lacked competency check information. Their agency provided no competency checklists. CNA WW lacked competency check information. Her agency only provided an undated, unsigned quiz. CNA UU lacked competency check information. On 11/14/22 at 08:50 AM, observation revealed Nurse Aide (NA) O and NA QQ both wore a strip of masking tape on their uniform with their first names and CNA. Further observation revealed the two aides used a total lift to transfer R17 from her bed to a wheelchair and then left her to eat on her own in her room. R17's care plan directed staff to supervise her when eating due to a risk for aspiration (ingesting food into the lungs). On 11/14/22 at 01:45 PM, NA O stated R17 was okay to eat on her own and she had never been told to stay and supervise R17 while she ate. On 11/15/22 at 09:21 AM, Administrative Nurse D stated the facility staffing coordinator contacted agencies for staffing daily, to supplement staff. She stated the facility contracted with some CNAs to work here for an extended period of six weeks so they could place them on the schedule. Administrative Nurse D stated the facility included the agency staff in education in-services if they were working that day. She stated agencies sent a packet with the staff's credentials and competencies to the facility. On 11/15/22 at 01:30 PM, Administrative Staff B verified the facility lacked competency evaluations of all agency direct care staff employed at the facility. Upon request the facility did not provide a policy related to staff competency and education. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility lacked competency records for all direct care staff, placing the residents who were cared for by facility staff at risk to not have their individual care needs met. 32360 - The Electronic Medical Record (EMR) for R5 documented diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). R5's Admission Minimum Data Set (MDS), dated [DATE], documented R5 had intact cognition and required supervision and setup help only for bed mobility, transfers, dressing, and personal hygiene. The MDS further documented R5 did not ambulate and was independent with toileting. The Care Plan, dated 10/13/22, documented R5 required assistance with all cares, had pain and directed staff to monitor for signs and symptoms of pain with each interaction. The Nurse's Note, dated 11/07/22, documented R5 continued with nausea and vomiting, was diabetic and not holding down any food or liquid. The note further documented staff contacted the physician and was ordered to send R5 to the emergency room (ER). The Nurse's Note, dated 11/07/22 at 10:32 PM, documented R5 returned from the ER with orders for Protonix (medication used to treat stomach acid), 40 milligram (mg) by mouth, in the morning. On 11/08/22 at 08:16 AM, observation revealed R5 sat in her wheelchair with an emesis pan on her lap and was vomiting. On 11/08/22 at 08:17 AM, this surveyor told Licensed Nurse (LN) H that R5 had vomited and needed assistance. LN H stated, No she isn't, she is at the hospital. This surveyor stated, The resident returned last evening and was in her room. LN H stated,Oh I did not know. LN H stated he had gotten to work late and did not get report. On 11/15/22 at 03:00 PM, Administrative Nurse D stated staff received report when they start their shift and that it was the nurse's responsibility to make sure they receive report regarding the residents. The facility did not provide a policy regarding competent nursing staff. The facility failed to ensure licensed nursing staff were aware of R5's return from the hospital, placing her at risk for unmet needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37450 The facility had a census of 106 residents. The sample included 28 residents. Based on observation, record review, and interview the facility failed to perform a reconciliation of controlled drugs at the beginning and end of daily worked shifts for five of six medication carts. This placed residents at risk for misappropriation of medications by staff. Findings included: On 11/14/22 at 08:54 AM, during morning medication pass observation revealed the South East Medication Cart controlled drug count book lacked signatures for beginning and end of daily shifts. Upon review of the six controlled drug count books revealed the following: Southwest Nurse Cart 09/25/22 through 10/06/22, 10/16/22 through 10/21/22, 10/25/22 through 10/28/22, 11/02/22, 11/03/22, 11/05/22, and 11/06/22. Southeast Medication Cart #1, 08/20/22, 08/21/22, 08/26/22 through 08/28/22, 08/31/22 through 09/05/22, 09/18/22 through 09/21/22, 09/26/22 through 10/21/22, 10/24/22 through 10/28/22. Southeast Medication Cart #2, 08/18/22 through 09/09/22, 09/11/22 through 09/18/22, 09/25/22 through 10/05/22, 10/10/22 through 10/21/22, 10/24/22 10/30/22, 11/01/22 through 11/07/22. Southeast Nurse Cart, 09/30/22 through 10/04/22, 10/10/22 through 10/13/22, 10/17/22, 10/18/22, 10/20/22, 10/21/22, 10/26/22, 10/27/22, and 11/04/22 through 11/08/22. North Certified Medication Care, 08/07/22, 08/30/22, 09/05/22, 10/26/22, 11/03/22, 11/09/22, and 11/10/22. On 11/14/22 at 08:54 AM Certified Medication Aide (CMA) R stated there should be signatures every day of on coming and off going staff. On 11/14/22 at 09:53 AM, Administrative Nurse D verified staff are to count the controlled medication and sign the count log at the beginning and end of each shift or when staff receive keys. The Controlled Substance Management policy, dated 08/2022, documented all controlled substances shall be counted at the change of each shift, and any handoff or narcotic keys. The facility failed to perform a reconciliation of controlled drugs at the end of daily work shift, for five of six medication carts, placing residents at risk for misappropriation of medications by staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27168 The facility had a census of 106 residents. The sample included 28 residents. Based on observation, record review, and interview, the facility to failed to store, prepare, and serve food under sanitary conditions for the 104 residents who received food from the facility kitchen. Findings included: - On 11/07/21 at 09:00 AM, observation revealed the stove range hood with a large amount of brownish grey fuzzy substance covering the top of the hood and the galvanized side wall panels. Further observation revealed three black fire suppression spigots covered with brownish grey fuzzy substance. Continued observation revealed on the exterior of the hood a large sticker that stated, Crown Cleaning, the sticker recorded the hood was cleaned October 24, 2022. (14 days). On 11/14/22 at 11:10 AM, observation revealed Dietary Staff CC in the kitchen with approximately one- and one-half inches of her bangs hanging out the top of the hair net and had wisps of hair hanging out of the back of the hair net. On 11/14/22 at 11:15 AM, observation revealed Dietary Aide DD in the kitchen, putting the plated food in plastic cover for transport of the meals to the halls with approximately one half of the forehead hair line to the top of the crown of the head not covered with any hair covering of her hair not in a hair net. On 11/14/22 at 11:25 PM, observation revealed Dietary Aide EE walked in the kitchen from an entrance door and walked from one side of the kitchen to the other to wash her hands, then placed a hair net on that just covered the top half of her hair from the bangs to the nape of her neck and the braids from the nape of the neck approximately 5 inches exposed and not contained in the hair net. On 11/14/22 at 11:55 AM observation revealed two dietary aides assisting with the noon meal service had hair nets on, but had wisp of hair out of the bottom of the hair net and the top of the hair net was not covering the entirety of their bangs. On 11/14/22 at 12:00 PM, observation revealed Dietary Staff FF walked from the facility hallway into the kitchen and crossed in front of the food plating area and started talking to the dietary manager without any hair covering on, then realized he did not have a hair net on and took one out of his pocket and placed it on his head while standing by the food serving cart in the kitchen. On 11/14/2022 at 12:10 PM, observation revealed the overhead return air grill, approximately three feet by eighteen inches, covered with brownish grey fuzzy substance, and eight 12 inch x 12 inch supply registers located above the food preparation area, dishwashing area and the pots and pan storage area covered with brownish grey fuzzy substance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/22 at 09:10 PM, Dietary Staff BB and Maintenance Staff U stated the range hood was last cleaned October 24, 2022 and verified the brownish grey substance was still on the hood and fire suppression spigots and verified it apparently was not cleaned thoroughly and verified the range hood needed cleaned. On 11/15/22 at 10:30 PM, Administrative Staff B stated the dietary staff should have hair nets on and hair contained in the hair nets at all times when in the kitchen. On 11/14/22 at 12:45 PM, Maintenance Staff U verified the registers and grills in the kitchen ceiling were covered with the brownish grey lint and did not have a schedule to clean them, but would initiated that task in his TELS (a building management platform to record maintenance tasks) and would complete the cleaning at least monthly. The facility's Food and Nutrition policy, dated October 2021, documented all employees are required to follow acceptable personal hygiene practice to ensure that food is prepared, stored and distributed in a safe and sanitary manner, preventing the spread of food borne illness. The policy recorded employees must wear hair nets and beard restraints required by local and federal health codes. No hair ornaments are permitted unless function as hair restraints. The Facility's Food and Nutrition Hood Venting System policy dated April 2021. documented the hood venting system shall be cleaned regularly by system professionals to reduce the potential of grease fire. Food and Nutrition Director or designee arranges with outside services for cleaning of hood ventilation system. Services is at least every six months. - more frequently as determined by cleanliness or lack thereof hood system. All hood systems in the facility are included in the service agreement, each hood will have a sticker attached that shows the date of last professional cleaning. Weekly and monthly cleaning of visible area of hood and filters are maintained by Nutrition or maintenance staff. The facility's Food and Nutrition Equipment policy, dated March 2022 policy, documented the food and Nutrition equipment shall be maintained in a good state of repair. Staff trained to report equipment that does not work or is not functioning properly. Supervisor for staff member reports problem to Maintenance Department according to facility procedure giving as much detail as needed to describe problem. Outside repair service is called if problem cannot be corrected in a reasonable time frame by facility maintenance department. The facility failed to store, prepare, and serve food under sanitary conditions for the 104 residents who received their meals prepared in the facility kitchen.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32358 The facility identified a census of 103 residents. Based on observations, record reviews, and interviews, the facility failed to maintain an effective quality assessment and assurance (QAA) program to identify and develop corrective actions plans and monitor them to correct identified quality deficiencies prior to survey. This deficient practice placed the resident's at risk for ineffective care. Findings Included: - The facility failed to provide adequate housekeeping and maintenance services to ensure a safe, clean, comfortable, homelike environment for Residents (R)5, R32, R56, R19, R18 on four of six halls of the facility. This deficient practice placed residents at risk for a less than pleasant homelike environment. (refer to F584) The facility failed to provide necessary services to maintain good personal hygiene, including bathing for R8, R22, R32, R2, R5, and R44. This placed the residents at risk for poor personal hygiene and infection. (Refer to F677) The facility failed to provide adequate supervision and identify potential causative factors to prevent future accidents for cognitively impaired R2. As a result, R2 sustained burn injuries to his fingers. (Refer to F689) The facility failed to ensure all direct care staff working with residents of the facility had adequate competency assessments. This deficient practice placed the 106 residents of the facility at risk to not have their individual care needs met, and failed to ensure licensed nursing staff possessed the necessary knowledge and awareness to care for R5, who had returned to the facility from the hospital. This placed the resident at risk for unmet needs. (Refer to F726) The facility failed to perform a reconciliation of controlled drugs at the beginning and end of daily worked shifts for five of six medication carts. This placed residents at risk for misappropriation of medications by staff. (Refer to F755) The facility failed to maintain sanitary dining services related to equipment cleaning, and safe food temperatures and storage during service. (Refer to F812) On 07/14/22 at 03:21 PM Administrative Staff A stated that he recently had become responsible for the facility and noted that many of the Quality Assurance and Performance Improvement (QAPI) documents were missing from the QAPI book. He was not able to provide any documentation for review related to identified facility concerns. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Quality Assurance and Performance Improvement plan effective 06/2022 noted that the facility will complete performance improvement projects with concentrated effort for a particular identified problem or a facility wide basis. The plan stated PIP's will be used to examine and improve care in areas that the facility had identified needing attention. The plan noted that the PIP's will be continuously documented to include overall goals, appropriate measures, root cause analysis findings, interventions, and overall conclusions. The facility failed to identify and develop corrective action plans for potential quality deficiencies through the QAPI plan to correct identified quality issues. This deficient practice placed the resident's at risk for ineffective care.

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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 32358 The facility had a census of 106 residents. The sample included 28 residents. Based on observation, record review, and interview, the facility lacked documentation of the facility's Quality Assessment and Assurance (QAA) program quarterly meeting for three of the four-month quarters within a year. This placed the residents who reside in the facility to identify areas of concern which contribute to the quality of care the residents may receive. Findings included: - On 11/14/22 at 01:24 PM, upon review of the facility's Quality Assurance Performance Improvement (QAPI) meeting attendance sheets, Administrative Staff A brought forth 08/18/22 with the required attendance from the meeting. Administrative Staff A reported she was unable to locate information regarding the QAA program and QAPI meetings from the past year, due to administrative changes. The undated and untitled facility policy stated the goal of the QAPI Program is to meet the center's mission through the collection and analysis of quality assessment data in an effort to proactively identify root causes of quality and performance issues, develop strategies and implement processes and systems for improvement to assure our patient's, resident's, and their families receive the best possible care and services. The facility failed to retain documentation and/or ensure the committee met at least quarterly for three of four quarters, which placed residents at risk of unidentified quality care services.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 106. The sample included 28 residents. Based on observation, record review, and interview the facility failed to place enhanced barrier precaution (approach of targeted gown and glove use during high contact resident care activities, to reduce transmission of infections) signage by Resident (R)61's door, who was positive with Carbapenem-Resistant Acinetobacter Baumannii (CRAB- causes infections of the blood, urinary tract, lungs, wounds, and other body sites which are very hard to treat due to antibiotic resistance) infection, staff failed to wear appropriate personal protective equipment (PPE-gowns, gloves, eyeshields, masks and other barrier equipment to protect and prevent transmission of communicable diease) when entering and providing care for R97 and R3, who were on enhanced barrier precautions for CRAB. The facility failed to provide appropriate education to staff regarding CRAB infection and failed to provide surveillance for CRAB infection for R3, R18, R24, R46, R47, R61, R64, R69, R8, R97, R259, and R260. This placed the 106 residents in the facility in Immediate Jeopardy due to the liklihood for ongoing transmission of CRAB as a result of the deficient infection control practices. The facility further failed to to disinfect a shared glucometer (instrument used to calculate blood glucose) between R10 and R71 which placed the residents at risk for bloodborne pathogens and infectious disease. Findings included: - The facility Carbapenamase Positive Resident List, dated 11/01/22, listed the following positive residents with date they were positive: R260 tested positive on skin 03/07/22 (no longer resides at facility) R259 tested positive on skin 03/12/22 (no longer resides at facility) R81 tested positive in wound 05/20/22 R46 tested positive in wound 06/01/22 R64 tested positive in wound 07/22/22 R69 tested positive on skin 07/29/22 R3, R18, R24, and R97 tested positive on skin 08/08/22 R61 and R47 tested positive on skin 10/18/22. The Infection Control Tracking Log Binder from 01/01/22 to 10/31/22 lacked documentation regarding the surveillance of CRAB infection. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/14/22 at 09:16 AM, Administrative Nurse D stated R259 and R260 were admitted from the hospital in March 2022 with the acinelobacter baumanni (CRAB). Kansas Department of Health and Environment (KDHE) was contacted. KDHE came out 08/08/22 and tested 84 residents and four were positive. KDHE came to the facility again 10/18/22 tested 82 residents and two new residents were positive. Administrative Nurse D stated not all the residents had been tested ; there were six left to be tested and KDHE was supposed to leave supplies for staff to test the six, but failed to leave them, so they have not been tested . On 11/14/22 at 03:30 PM, Administrative Nurse D verified the facility lacked surveillance of the CRAB infection and stated staff should had developed a system for surveillance of the infection. On 11/14/22 at 4:30 PM, Consultant Staff (CS) HH stated KDHE originally found out about positive cases of CRAB from the local hospital and a sample was sent to the lab and regional lab in Minnesota. They look to determine if they have enzyme that would spread infection. CS HH stated KDHE conducted an investigation by locating where the residents were transferred. KDHE contacted the facility to make sure they were aware the resident was positive for CRABS. At this time the facility was instructed to place the resident on enhanced barrier precautions indefinitely. KDHE had the facility fill out a form with information regarding the roommate's acuity of care, wound care, on vent, or indwelling medical device. CS HH stated the first case had been identified on 06/08/22 and they contacted facility on 06/09/22 either by e-mail or phone and instructed the facility to place the resident on enhanced barrier precautions. CS HH stated KDHE went to the facility on [DATE] for Icare (investigation) focus to educate what it meant to be on enhanced barrier precautions and the importance of how to prevent transmission. The education was given to Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), housekeeping supervisor, maintenance supervisor and nurse consultant. CS HH stated on 08/08/22 KDHE staff went back to facility, conducted screening tests with auxiliary swab on residents present in the facility. Some were in therapy or out of facility so were not tested . KDHE went back on 10/27/22 conducted second screening on residents available in the facility, which left six residents to screen. CS HH stated KDHE staff were supposed to leave supplies for facility staff to test the six remaining residents, but somehow it fell into the gaps and KDHE did not leave the supplies. CS HH stated the plan now was for KDHE staff to go back to facility (not sure when) to reeducate on infection control (CRAB) education, make sure everyone is on the same page, so there is improvement on prevention of spread of CRABS, and talk about whether they should conduct screenings until the facility had identified no new cases of the CRAB. The facility's Infection Control Program Policy, revised 01/22, documented surveillance data and reported information would be used to inform the committee of potential issues and trends. Surveillance tools would be used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. The policy documented data analysis would be gathered during surveillance and used to oversee infections and spot trends. Important facets of infection prevention include identifying possible infections or potential complications of existing infections, and instituting measures to avoid complications or dissemination. The policy documented staff and nursing would be educated so they could adhere to proper techniques and procedures. The policy documented Enhanced screening for possible significant pathogens would be developed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The antibiotic stewardship policy last revised 12/19 documented antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. Antibiotic stewardship refers to a set of commitments and activities designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The core elements of the program are our leadership commitment, accountability, drug expertise, tracking, actions, reporting and education. The facility failed to provide ongoing surveillance of the CRAB infection. This placed the 106 residents at risk for acquiring the infection. - On 11/07/22 at 03:59 PM, observation revealed R61 (positive resident for CRAB) lacked signage related to enhanced precautions during direct care by the resident's room and R61's care plan lacked a section regarding CRAB infection. On 11/07/22 at 03:45 PM, observation revealed CNA PP entered R3's (on barrier precautions for positive CRAB) room without a gown, applied gloves, provided incontinent cares, removed and discarded gloves, used hand sanitizer (did not wash hands) and left the room . Further observation revealed CNA PP went to the nurse's station, then answered a call light on the other hall and went into an uninfected resident's room. On 11/07/22 at 03:59 PM, CNA PP verified she had not placed a gown on prior to providing incontinent cares for R3 and was unaware she had to. On 11/14/22 at 04:05 PM, observation revealed, Certified Nurse Aide (CNA) NN entered R97's room (who was on enhanced barrier precautions for CRAB), without gowning, placed gloves on and touched R97's indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag), opened the trash can lid with used personal protective equipment (PPE), pushed down the items with gloved hand touching them on her arms, then removed and discarded gloves, without washing hands left the resident's room. Further observation revealed the isolation cart outside R97's room lacked gowns. Further observation revealed CNA NN went up and down the hall, then grabbed another aide and donned on a gown and went back into the same resident's room. On 11/14/22 at 04:05 PM, CNA NN verified she had not placed a gown on prior to entering R97's room and stated she was in a hurry to answer the call light. On 11/15/22 at 01:41 PM, Administrative Nurse D stated staff should follow enhanced barrier precautions when entering positive CRAB resident's rooms. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Enhanced Barrier Precautions (EBP) Policy, dated 08/22, documented enhanced barrier precautions would be initiated for residents as applicable in accordance with Centers for Medicare and Medicaid (CMS) and/or state regulations and or in accordance with CDC guidance to reduce the risk of transmission of multiple drug resistant organisms to others. Enhanced barrier precautions is applicable for residents with any of the following infection or colonization with Multi Drug Resistant Organisms (MDRO) for wounds and/or indwelling medical devices (central line (catheter that is placed in a large vein), urinary catheter, feeding tube(tube for introducing high calorie fluids into the stomach), trach(opening though the neck into the trachea through which an indwelling tube may be inserted)/vent(a device that supports or recreates the process of breathing by pumping air into the lungs) regardless of MDRO colonization (presence of microorganisms that can cause infection but not to the infection itself) status . EBP requires wearing disposable gloves and an isolation gown prior to high contact activity. Face protection may also be needed/worn if performing activities with risk of splash or spray. Hand hygiene should be performed before and after each resident contact and after removing personal protective equipment. High contact resident care activities include Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care any skin opening requiring a dressing does not require the resident be confined to his/her room. Initiation or discontinuation of EBP does not require a physician order. The resident may be cohorted with other resident with the same MDRO or if not possible, with another resident who is not immunocompromised or at risk for transmission, no open wounds or indwelling devices)dedicated non critical resident care equipment (blood pressure cuff, stethoscope, thermometer) should be maintained in the resident's room for use. The facility failed to use the required PPE during cares for R96 and R3 and failed to implement enhanced barrier precautions for R61 to prevent the spread of infection. This placed the 106 residents at risk for acquiring the CRAB infection. - On 11/15/22, the facility lacked documentation all relevant staff were educated on CRAB infection. On 11/15/22 at 8:14 AM, Licensed Nurse (LN) L stated the facility had not provided in-services to staff regarding CRAB infections due to a lot of the staff being agency. LN L stated staff were to read the signage by the positive resident's doors and if she saw new agency staff she would grab them and educated them individually. On 11/15/22 at 2:00 PM, Administrative Nurse D stated staff were educated in an in-service regarding donning of Personal Protective Equipment (PPE) for isolation precautions, but not specifically for CRAB and enhanced barrier precautions. Administrative Nurse D stated staff were also educated by reading the education signs located on the walls in the halls and if staff were from agency, facility staff tried to grab the agency staff when they came to work their shift and educate them. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/17/22 at 10:30 AM with Consultant Epidemiologist (scientist who studies the causes, distribution of, and appropriate countermeasures for health-related issues or events) KK revealed she spoke with the facility administration in May 2022 regarding the resident that was positive for CRAB. The state agency for health and environment (KDHE) conducted resident testing on all residents who were in the facilty the day of testing. Consultant KK stated there were residents who were not available for testing at that time. She stated the facility was instructed to do terminal cleaning daily on all rooms where a CRAB positive resident resided, and to ensure that housekeeping staff used proper dwell times (amount of time chemical left in surface to effectively kill bacteria) for the cleaning agents that were being used. She said the facility was instructed to clean all common areas daily as well and further instructed that cohorting CRAB positives residents only with other CRAB positive residents would be best practice. The Centers for Disease Control and Prevention (CDC) on the government website www.cdc.com listed the follwoing guidance Implementation of Personal Protective Equipment use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms updated July 12, 2022, Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing [11-15]. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The guidance further documents that nursing homes should train staff regarding Enhanced Barrier Precautions and MDRO's. The facility's Enhanced Barrier Precautions (EBP) Policy, dated 08/22, documented enhanced barrier precautions would be initiated for residents as applicable in accordance with Centers for Medicare and Medicaid (CMS) and/or state regulations and or in accordance with CDC guidance to reduce the risk of transmission of multiple drug resistant organisms to others. Enhanced barrier precautions is applicable for residents with any of the following infection or colonization with Multi Drug Resistant Organisms (MDRO) for wounds and/or indwelling medical devices (central line (catheter that is placed in a large vein), urinary catheter, feeding tube(tube for introducing high calorie fluids into the stomach), trach(opening though the neck into the trachea through which an indwelling tube may be inserted)/vent(a device that supports or recreates the process of breathing by pumping air into the lungs) regardless of MDRO colonization (presence of microorganisms that can cause infection but not to the infection itself) status . EBP requires wearing disposable gloves and an isolation gown prior to high contact activity. Face protection may also be needed/worn if performing activities with risk of splash or spray. Hand hygiene should be performed before and after each resident contact and after removing personal protective equipment. High contact resident care activities include Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care any skin opening requiring a dressing does not require the resident be confined to his/her room. Initiation or discontinuation of EBP does not require a physician order. The resident may be cohorted with other resident with the same MDRO or if not possible, with another resident who is not immunocompromised or at risk for transmission, no open wounds or indwelling devices) dedicated noncritical resident care equipment (blood pressure cuff, stethoscope, thermometer) should be maintained in the resident's room for use. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Infection Control Program Policy, revised 01/22, documented surveillance data and reported information would be used to inform the committee of potential issues and trends. Surveillance tools would be used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. The policy documented data analysis would be gathered during surveillance and used to oversee infections and spot trends. Important facets of infection prevention include identifying possible infections or potential complications of existing infections, and instituting measures to avoid complications or dissemination. The policy documented staff and nursing would be educated so they could adhere to proper techniques and procedures. The policy documented Enhanced screening for possible significant pathogens would be developed. The antibiotic stewardship policy last revised 12/19 documented antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. Antibiotic stewardship refers to a set of commitments and activities designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The core elements of the program are our leadership commitment, accountability, drug expertise, tracking, actions, reporting and education. The facility failed to educate all staff on CRAB infections. This placed the 106 residents at risk for acquiring the infection. The facility's failure to educate all staff on CRAB infections, failure to provide ongoing surveillance of the CRAB infection, and failure to use the required PPE during cares for R96 and R3 and failed to implement enhanced barrier precautions for R61 to prevent the spread of infection placed all the residents in the facility in Immediate Jeopardy due to the liklihood of continued internal transmission of CRAB. The facility removed the immediacy on 11/16/22 when the facility placed all untested residents on enhanced barrier precautions until testing and surveilience is completed. All care plans and Kardex were updated with precaution information. Staff received education on CRAB, MDRO, hand hygiene, environmental cleaning, and PPE. The facility communicated the enhanced barrier precautions to residents and family members and discussed with resident council. The deficient practice remained at a scope and severity of F.' - On 11/07/22 at 12:23 PM, observation revealed Licensed Nurse (LN) J checked R10's blood sugar with a shared glucometer. Then without disinfecting the glucometer checked R71's blood sugar. On 11/07/22 at 12:30 PM, LN J verified she had not disinfected the shared glucometer and was unaware she should. On 11/15/22 at 01:41 PM, Administrative Nurse D stated staff should disinfectant a shared glucometer between residents with micro kill disinfectant . The facility failed to disinfectant a shared glucometer between R10 and R71. This placed the residents at risk for acquiring a bloodbourne pathogen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175172	A. Building B. Wing	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 32358 The facility had a census of 106 residents. The sample included 28 residents. Based on interview and record review the facility failed to provide an Infection Preventionist (IP) to manage and monitor the facility's Infection Prevention and Control Program (IPCP) for the 106 residents who reside in the facility. This placed the residents at risk for infections and health problems. Findings included: - On 11/14/22 at 03:00 PM, Administrative Nurse D stated the facility had no certified IP to provide oversight and monitor the facility's IPCP. The Infection Preventionist Policy, dated August 2019, directed the facility to maintain an IP to coordinate the development and monitoring of the facility's established infection prevention and control policies and practices. The facility failed to provide an IP to manage and monitor the facility's Infection Prevention and Control Program for the 106 residents who reside in the facility, placing the residents at risk for infections and health problems.