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	02/08/2023

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 111 residents. The sample include 14 residents with three resident reviewed for neglect. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 4 remained free from neglect when staff failed to provide the necessary cares as directed by R4's plan of care to promote her overall wellbeing and safety. This deficient practice placed R4 at risk for impaired physical and psychosocial wellbeing due to neglect. Findings Included: -The Medical Diagnosis section within R2's Electronic Medical Records (EMR) included diagnoses of persistent vegetative state (disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness), acute respiratory failure, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anoxic brain damage (complete lack of oxygen to the brain), tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted), gastrostomy (surgical creation of an artificial opening into the stomach thru the abdominal wall), and stiffness of joints. R4's Annual Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated R1 was totally dependent on two staff members for mobility, transfers, bathing, dressing, locomotion, toileting, and personal hygiene. The MDS noted she had a feeding tube and tracheostomy. The MDS indicated R4 had no falls since admission. A review of R4's Activities of Daily Living (ADLs) Care Area Assessment (CAA) completed 08/21/22 indicated that due to her medical diagnoses she was dependent on staff for all ADLs. The CAA noted that all nutrients are provided via her feeding tube. The CAA noted that she used a Broda chair (specialized wheelchair with the ability to tilt and recline) when not in bed. R4's Care Plan for ADLs initiated 12/11/19 indicated that she required total dependence for assistance from two staff all ADL's except meals. The care plan noted she required a Hoyer lift for transfers. The care plan noted that resident does not participate in bed mobility or transfers and cannot assist herself with rolling on or off lift sheets during transfers. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Care Plan for Respiratory Care initiated 12/11/19 indicated that she had a tracheostomy. The plan indicated that staff should perform tracheostomy care daily and as needed using aseptic technique (12/11/19) The plan instructed staff to monitor R4 for signs of aspiration, fever, shortness of breath, tube dislodgment or dysfunction, or abnormal breathing sounds (12/11/19). The plan instructed nursing staff to monitor the humidifier, stoma site, and to provide supplemental oxygen as necessary (12/11/19). R 4's Care Plan for Falls initiated 12/16/19 indicated that she has had an actual fall related to immobility. The plan instructed staff to anticipate her needs, be sure call light is within reach (12/16/19), ensure bed is in the lowest position (01/09/23), and use positioning devices 11/06/22). A review of R4's EMR revealed a Self Care and Mobility evaluation dated 10/25/22 noted R4 was dependent on staff assistance for mobility movements including transitioning from sitting to lying positions, lying to sitting on side of bed, toileting transfers, and toileting hygiene. The evaluation noted that walking, chair to chair transfers, and sit to stand transitions were not attempted due to medical/safety concerns. A review of R4's EMR under Nursing Clinical Evaluation dated 08/09/22 indicated that R4's feeding tube had become displaced during peri-care check and change. A review of R4's EMR under Change of Condition note indicated upon entering the nurse observed R4's tracheotomy tube pulled out and lying on her chest. R4 was sent to an acute care facility for placement. The EMR lacked documentation investigating the cause of the dislodgement. A review of R4's EMR under Nursing Clinical Evaluation dated 01/01/23 indicated upon entering the nurse observed R4's tracheotomy tube pulled out and lying on her chest. R4 was sent to an acute care facility for placement. The EMR lacked documentation investigating the cause of the dislodgement. A review of R4's EMR under Nursing Clinical Evaluation dated 01/09/23 indicated direct care heard R4's roommate (R15) yelling out for help from the room. The note indicated that R4 was found by staff on the floor. The note revealed she was on her back in between her and her roommate's bed. The nurse noted that R4's feeding tube had been pulled out and she had a laceration on the back of her head. R4 was sent to out to an acute care facility for evaluation and treatment. The EMR lacked documentation investigating the cause of the dislodgement. A review of R4's Fall Report noted that R4 was found on the floor at 07:45PM on 01/09/23. The report noted that staff provided cares to her last ay 06:00PM. The report indicated that R4 had a 0.5-centimeter (cm) laceration to the back of her head and her feeding tube was dislodged. A review of a Witness Statement completed on 01/09/23 indicated that the responding staff heard yelling from R4's room and observed R4 on the floor tangled up in her feeding tube. The statement noted that R4's bed at the time of the fall was not in the lowest leveled position. The statement indicated that the head of the bed was raised in the up position while the foot of the bed was still in the low position. A review of R4's Medication Administration Report (MAR) under Tracheostomy care orders revealed that R4 did not receive scheduled trach care, suctioning, oxygen therapy, or tracheostomy site assessment on the evening of 02/04/23. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R4's Medication Administration Report (MAR) under Enteral Feeding orders revealed that R4 did not receive her scheduled evening feeding tube flush, stoma assessment, and tube cleansing with soap and water on the evening of 02/04/23. A review of R4's Medication Administration Report (MAR) indicated her evening pain assessment was not completed on the evening of 02/04/23. On 02/08/23 at 01:42PM R4 was in her bed. R4's bed contained a concave mattress and in the lowest position. R4 awake but not responsive to questions. R4's television was on but she was facing the room's window. On 02/08/23 at 01:50PM in an interview with R15 (R4's roommate) stated that on 01/09/23 she woke up and found R4 lying on her back next to her bed. She stated that she did not see anyone in the room and started yelling for staff to come help. On 02/08/23 at 02:00PM Consultant JJ reported that R4 was completely dependent on staff for all ADLs, movement, repositioning, and transfers. She stated R4 does have tonic movement (stiffness or tension in the muscles) but not sure how she would end up on floor. She stated that R4 was conscious at time but not alert and oriented to her surroundings and could not move freely. On 02/08/23 at 03:13PM Certified Nurses Aid (CMA) R stated that that he is familiar with R4's care needs. He stated that she was a total care resident. He stated that R4 is not capable of moving herself or make her needs known. CMA R stated that he was not aware of how R4 would end up on the floor but stated that it may have been bad positioning, her bed being too high, or lack of staff rounding and frequently checking in on her. He stated that the facility is often understaffed. On 02/08/23 at 03:35PM Licensed Nurse (LN) L stated that R4 was a total care resident hat required assistance for all of her ADLs. He stated that if R4 had a fall he would want to know the cause of the fall due to her medical conditions and inability to move on her own. He stated that staff are required to immediately report and investigate the cause of the fall. He stated that R4 can't verbalize her needs or communicate with staff. He stated she can't move on her own without assistance from staff. He stated that staffing was an ongoing concern for the facility. LN H noted that staff often call off a lot and leave the residents of the facility without the proper care at times. He stated that he has been the only nurse working short staffed on about seven or eight occasions. He stated that basic cares and tasks often will not be completed due to the acuity and high census of the resident when staff call off or don't show up to work. On 02/08/23 at 04:00PM Administrative Nurse D stated that nurses were expected to asses the residents during falls, complete neurological checks, and report the falls to the interdisciplinary team (IDT). She stated that if a fall occurred unwitnessed then we would have to determine what caused the fall and rule out abuse. She stated that she was not aware of the details related to R4's fall or how she ended up on the floor. She stated that possible causes of the fall could be pain, direct care staff not properly positioning R4 back in bed, or possibly R4's roommate. She stated that the IDT team would meet to discuss any possible abuse allegations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Abuse revised 02/2019 indicated that the facility prohibits the mistreatment, neglect, and abuse of residents. The policy noted that the facility's administrator and director of nursing are responsible for the investigation and reporting. The policy noted that facility is responsible for reporting , monitoring, screening, protection, and investigation of residents from abuse. The facility failed prevent neglect for R4. This deficient practice placed R4 at risk for adverse physical and psychosocial outcomes for R4.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 111 residents. The sample include 14 residents with one resident reviewed for abuse and/or neglect. Based on observation, record review, and interviews, the facility failed to ensure incidents of R4's neglect were reported, as required, to the State Agency. This placed the residents at risk for unidentified and ongoing abuse and /or neglect. Findings Included: - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of persistent vegetative state (disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness), acute respiratory failure, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anoxic brain damage (complete lack of oxygen to the brain), tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted), gastrostomy (surgical creation of an artificial opening into the stomach thru the abdominal wall), and stiffness of joints. R4's Annual Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated R4 was totally dependent on two staff members for mobility, transfers, bathing, dressing, locomotion, toileting, and personal hygiene. The MDS noted she had a feeding tube and tracheostomy. The MDS indicated R4 had no falls since admission. A review of R4's Activities of Daily Living (ADLs) Care Area Assessment (CAA) completed 08/21/22 indicated that due to her medical diagnoses she was dependent on staff for all ADLs. The CAA noted that all nutrients are provided via her feeding tube. The CAA noted that she used a Broda chair (specialized wheelchair with the ability to tilt and recline) when not in bed. R4's Care Plan for ADLs initiated 12/11/19 indicated that she required total dependence for assistance from two staff all ADL's except meals. The care plan noted she required a Hoyer lift for transfers. The care plan noted that resident does not participate in bed mobility or transfers and cannot assist herself with rolling on or off lift sheets during transfers. R4's Care Plan for Respiratory Care initiated 12/11/19 indicated that she had a tracheostomy. The plan indicated that staff should perform tracheostomy care daily and as needed using aseptic technique (12/11/19) The plan instructed staff to monitor R4 for signs of aspiration, fever, shortness of breath, tube dislodgment or dysfunction, or abnormal breathing sounds (12/11/19). The plan instructed nursing staff to monitor the humidifier, stoma site, and to provide supplemental oxygen as necessary (12/11/19). R4's Care Plan for Falls initiated 12/16/19 indicated that she has had an actual fall related to immobility. The plan instructed staff to anticipate her needs, be sure call light is within reach (12/16/19), and ensure bed is in the lowest position (01/09/23). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R4's EMR revealed a Self-Care and Mobility evaluation dated 10/25/22 noted R4 was dependent on staff assistance for mobility movements including transitioning from sitting to lying positions, lying to sitting on side of bed, toileting transfers, and toileting hygiene. The evaluation noted that walking, chair to chair transfers, and sit to stand transitions were not attempted due to medical/safety concerns. A review of R4's EMR under Nursing Clinical Evaluation dated 01/09/23 indicated direct care heard R4's roommate (R15) yelling out for help from the room. The note indicated that R4 was found by staff on the floor. The note revealed she was on her back in between her and her roommate's bed. The nurse noted that R4's feeding tube had been pulled out and she had a laceration on the back of her head. R4 was sent to out to an acute care facility for evaluation and treatment. The EMR lacked documentation investigating the cause of the dislodgement. A review of R4's Fall Report noted that R4 was found on the floor at 07:45PM on 01/09/23. The report noted that staff provided cares to her last ay 06:00PM. The report indicated that R4 had a 0.5-centimeter (cm) laceration to the back of her head and her feeding tube was dislodged. A review of a Witness Statement completed on 01/09/23 indicated that the responding staff heard yelling from R4's room and observed R4 on the floor tangled up in her feeding tube. The statement noted that R4's bed at the time of the fall was not in the lowest leveled position. The statement indicated that the head of the bed was raised in the up position while the foot of the bed was still in the low position. On 02/08/23 at 01:42PM R4 was in her bed. R4's bed contained a concave mattress and in the lowest position. R4 awake but not responsive to questions. R4's television was on but she was facing the room's window. On 02/08/23 at 01:50PM in an interview with R15 (R4's roommate) stated that on 01/09/23 she woke up and found R4 lying on her back next to her bed. She stated that she did not see anyone in the room and started yelling for staff to come help. On 02/08/23 at 02:00PM Consultant JJ reported that R4 was completely dependent on staff for all ADLs, movement, repositioning, and transfers. She stated R4 does have tonic movement (stiffness or tension in the muscles) but not sure how she would end up on floor. She stated that R4 was conscious at time but not alert and oriented to her surroundings and could not move freely. On 02/08/23 at 03:13PM Certified Nurses Aid (CMA) R stated that that he is familiar with R4's care needs. He stated that she was a total care resident. He stated that R4 is not capable of moving herself or make her needs known. CMA R stated that he was not aware of how R4 would end up on the floor but stated that it may have been bad positioning, her bed being too high, or lack of staff rounding and frequently checking in on her. He stated that the facility is often understaffed. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 02/08/23 at 03:35PM Licensed Nurse (LN) L stated that R4 was a total care resident that required assistance for all of her ADLs. He stated that if R4 had a fall he would want to know the cause of the fall due to her medical conditions and inability to move on her own. He stated that staff are required to immediately report and investigate the cause of the fall. He stated that R4 can't verbalize her needs or communicate with staff. He stated she can't move on her own without assistance from staff. He stated that staffing was an ongoing concern for the facility. LN H noted that staff often call off a lot and leave the residents of the facility without the proper care at times. He stated that he has been the only nurse working short staffed on about seven or eight occasions. He stated that basic cares and tasks often will not be completed due to the acuity and high census of the resident when staff call off or don't show up to work. On 02/08/23 at 04:00PM Administrative Nurse D stated that nurses are expected to asses the residents during falls, complete neurological checks, and report the falls to the interdisciplinary team. She stated that if a fall occurred unwitnessed then staff would have to determine what caused the fall. She stated that she was not aware of the details related to R4's fall or how she ended up on the floor. She stated that possible causes of the fall could be pain, direct care staff, not properly positioned back in bed, or possibly roommate. She stated that the IDT team would meet to discuss any possible abuse allegations and dtermine what was reportable. A review of the facility's Abuse revised 02/2019 indicated that the facility prohibits the mistreatment, neglect, and abuse of residents. The policy noted that the facility's administrator and director of nursing are responsible for the investigation and reporting. The policy noted that facility is responsible for reporting , monitoring, screening, protection, and investigation of residents from abuse. The facility failed to ensure incidents of R4's neglect were reported, as required, to the State Agency. This placed the residents at risk for unidentified and ongoing abuse and /or neglect.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42966 The facility identified a census of 102 residents. The sample included 22 residents with four residents reviewed for bathing. Based on observations, record review, and interviews, the facility failed to provide consistent bathing for Resident (R) 19 and R22. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for the affected residents. Findings included: - The Diagnoses tab of R19's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness and abnormal posture. The Annual Minimum Data Set (MDS) dated [DATE], documented R19 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R19 required extensive assistance with bed mobility and dressing; total physical dependence with two staff for transfers and toileting; extensive assistance with one staff for bathing; limited assistance with one staff for personal hygiene; and supervision with setup help only with eating. The Quarterly MDS dated [DATE], documented R19 had a BIMS score of 15 which indicated intact cognition. R19 required extensive assistance with two staff for bed mobility; extensive assistance with one staff for dressing and bathing; total dependence with two staff for transfers and toileting; limited assistance with one staff for personal hygiene; and was independent with setup help for locomotion and eating. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/07/22, documented R19 required extensive assistance with bed mobility and total dependence with two staff and Hoyer lift (mechanical lift) for transfers. The Care Plan dated 11/23/21, documented R19 required assistance with ADLs related to impaired mobility and documented an intervention, dated 05/01/22, for bath/shower on Monday and Thursday evenings. The Tasks tab of R19's EMR documented a task for Bath/Shower: Monday and Thursday Evenings. Review of the Task history for the last 30 days revealed the following bathing information: R19 received bathing on 02/27/23; refused bathing on 03/16/23 and 03/23/23; and had Not Applicable (NA) documented on 03/06/23, 03/20/23, and 03/27/23. On 03/29/23 at 01:15 PM, R19 laid in bed and appeared comfortable, conversed with the surveyor. R19 stated bathing was improving but she did not get baths/showers regularly. She stated she asked staff to give her bed baths when they were not able to give her a bath/shower. On 03/29/23 at 02:02 PM, Licensed Nurse (LN) G stated Certified Nurse Aides (CNA) were responsible for bathing and there was a binder with a shower schedule in it. She stated the CNAs had a paper they filled out when bathing was completed that they gave to the nurse. The nurse reviewed it for any skin issues and signed it. Bathing was also documented in Point of Care (POC- CNA EMR documentation system) and staff were discouraged to use NA. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/23 at 02:29 PM, CNA N stated the shower aides were responsible for bathing, if there was no shower aide then the CNA assigned to the hall was responsible for completing bathing for the assigned showers on the hall that day. She stated bathing was documented in POC and on a shower sheet that was then given to the nurse. CNA N stated showers might not get done if they were short staffed or had unexpected problems and that she used NA if she did not get to the shower. The facility's ADL- Bath (Shower) policy, last revised July 2019, directed it was the policy of the facility to shower residents, to cleanse and refresh the residents, observe the skin, and to provide increased circulation. The facility failed to provide consistent bathing for R19. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for R19. - The Diagnoses tab of R22's Electronic Medical Record (EMR) documented diagnoses for personal history of transient ischemic attack (a temporary period of symptoms similar to those of a stroke) and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], documented R22 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R22 required extensive assistance with one staff for bed mobility, dressing, bathing, and toileting; limited assistance with transfers; supervision with setup help for personal hygiene and eating; and was independent with setup help for locomotion. The Quarterly MDS dated [DATE], documented a BIMS score of 15 which indicated intact cognition. R22 required supervision with setup help for bed mobility, transfers, dressing, eating, toileting, and personal hygiene; bathing did not occur. The Care Plan dated 10/26/21, documented R22 required assistance with activities of daily living (ADLs) related to reduced mobility and documented an intervention, dated 06/13/22, that 22 received shower/bath Monday and Thursday evenings. The Tasks tab of R22's EMR documented a task for Bath/Shower: Monday and Thursday Evenings. Review of the Task history for the last 30 days revealed the following bathing information: R22 received a shower/bath on 03/20/23; refused bathing on 03/16/23 and 03/23/23; and had Not Applicable (NA) documented on 03/06/23 and 03/27/23. On 03/29/23 at 01:19 PM, R22 laid in bed and appeared comfortable, conversed with the surveyor. R22 stated she was not getting bathing regularly and some weeks, staff do not even ask if they want bathing. She stated when she does not get bathing regularly, she does not feel as good as she could if she had received bathing. On 03/29/23 at 02:02 PM, Licensed Nurse (LN) G stated Certified Nurse Aides (CNA) were responsible for bathing and there was a binder with a shower schedule in it. She stated the CNAs had a paper they filled out when bathing was completed that they gave to the nurse. The nurse reviewed it for any skin issues and signed it. Bathing was also documented in Point of Care (POC- CNA EMR documentation system) and staff were discouraged to use NA. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/23 at 02:29 PM, CNA N stated the shower aides were responsible for bathing, if there was no shower aide then the CNA assigned to the hall was responsible for completing bathing for the assigned showers on the hall that day. She stated bathing was documented in POC and on a shower sheet that was then given to the nurse. CNA N stated showers might not get done if they were short staffed or had unexpected problems and that she used NA if she did not get to the shower. The facility's ADL- Bath (Shower) policy, last revised July 2019, directed it was the policy of the facility to shower residents, to cleanse and refresh the residents, observe the skin, and to provide increased circulation. The facility failed to provide consistent bathing for R22. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for R22.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45668 The facility identified a census of 111 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to ensure Resident (R) 8 was administered the scheduled insulin (a hormone that regulates blood sugar) as ordered by their primary physician. This deficient practice placed R8 at risk for elevated blood sugar levels and possible adverse consequences. Findings included: - R8's Electronic Medical Record (EMR) recorded a diagnosis of type 2 diabetes mellitus (DM-when the body cannot regulate blood glucose levels). R8's Care Plan dated 05/26/22 directed staff to administer medications as per physician orders. R8's EMR recorded a Physician's Order dated 01/07/23 for insulin aspart (a short-acting insulin)100 units/milliliter (ml) to inject four units SQ before meals and at bedtime for DM. R8's EMR recorded another Physician's Order for insulin aspart 100 units/ml to inject per sliding scale (if blood sugar 70 - 140 give 0 units; 141 - 180 give one unit; 181-220 given two units; 221 - 260 give three units; 261 - 320 give four units); 321 - 400 give five units; 401- 450 give six units; 451 -500 give seven units; 501 - 600 give eight units, SQ before meals and at bedtime for DM if greater than 501, send to emergency room . Review of R8's February 2023 Medication Administration Record (MAR) revealed R8 was not administered the scheduled aspart insulin on 02/04/23 at 09:00 PM, or on 02/06/23 at 04:30 PM. The February 2023 MAR documented R8 was not administered the sliding scale aspart insulin on 02/04/23 at 09:00 PM, and 02/06/23 at 04:30 PM. On 02/08/23 at 03:54 PM Administrative Nurse D stated these residents did not receive their insulin because there was not a nurse on duty to administer the medication. The facility policy Medication Administration - Documentation last revised January 2019 documented: The facility shall maintain a MAR to document all medications administered. Documentation must include, at a minimum: name and strength of drug; dosage; method of administration; date and time of administration; reason(s) why a medication was withheld, not administered, or refused; and signature and title of the person administering the medication. The facility failed to ensure staff administered R8 the physician ordered insulin as prescribed. This placed R8 at risk for increased blood sugar levels and other adverse effects. (Refer to F725)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 102 residents. The sample included 22 residents with three residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to follow wound care orders and prevent cross-contamination during wound care for Resident (R) 16. This deficient practice had the risk for delayed wound healing and physical complications for R16. Findings included: - The Diagnoses tab of R16's Electronic Medical Record (EMR) documented diagnoses of senile degeneration of brain (decrease in cognitive abilities or mental decline), adult failure to thrive, generalized muscle weakness, and difficulty in walking. The Significant Change Minimum Data Set (MDS) dated [DATE], documented R16 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R16 required extensive assistance with one staff for bed mobility and personal hygiene; total physical dependence with two staff for transfers, toileting, and bathing; extensive assistance with two staff for dressing; and supervision with setup help only for eating. R16 had one stage three (full-thickness skin loss potentially extending into the subcutaneous [innermost layer of skin in your body] tissue layer) pressure ulcer. The Quarterly MDS dated [DATE], documented R16 had a BIMS score of eight which indicated moderate cognitive impairment. R16 required extensive assistance with one staff for bed mobility and personal hygiene; total physical dependence with two staff for transfers and bathing; extensive assistance with two for dressing and toileting; and supervision with setup help only for eating. R16 had one stage three pressure ulcer and one unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough [yellow/white material in the wound bed] and/or eschar [dry, dead tissue within a wound]) pressure ulcer. The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 08/22/22, documented R16 was at risk for pressure ulcers and she had one stage three pressure ulcer. The Care Plan dated 10/05/22, documented R16 had an alteration in skin integrity and had a stage three pressure ulcer to right buttock, stage four (full-thickness skin and tissue loss- these sores extend below the subcutaneous fat into the deep tissues, including muscle, tendons, and ligaments) pressure ulcer to left ankle, and an unstageable pressure ulcer to the sacrum (large triangular bone between the two hip bones). The Care Plan directed staff monitored the wound daily for signs and symptoms of infection and monitored the dressing daily to ensure it was clean, dry, and intact. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Orders tab of R16's EMR documented an order with a start date of 03/23/23 to cleanse left lateral ankle with normal saline (solution used to cleanse wounds), pat dry, apply skin-prep (a solution when applied that forms a protective waterproof barrier on the skin) to periwound (around the wound) and cover with bordered gauze (absorptive dressing that consists of three layers to ensure wound healing) daily and as needed (PRN) every day shift for left ankle wound care; an order with a start date of 03/23/23 for Therahoney sheet (gauze dressing covered in medical-grade honey) with instructions to cleanse sacrum with normal saline solution, pat dry, apply skin-prep to periwound, cut honey sheet to size and cover with bordered gauze every day shift for wound care; and an order with a start date of 03/23/23 for Therahoney sheet with instructions to cleanse right buttock with normal saline solution, pat dry, apply skin prep to periwound, cut honey sheet to size and cover with bordered gauze every day shift for wound care. On 03/29/23 at 09:59 AM, Licensed Nurse (LN) H and Certified Nurse Aide (CNA) M donned (put on) isolation gown and gloves to enter R16's room for wound care. LN H and CNA M transferred R16 from her wheelchair to the bed using a Hoyer lift (mechanical lift). Both staff removed the lift sling from underneath R16, her shoes, and her pants. LN H doffed (removed) gloves, washed her hands, then donned new gloves. She placed a clean barrier at the foot of the bed, placed supplies on the clean barrier, and poured normal saline in a cup with gauze. While CNA M held R16 on her right side, LN H cleansed her buttocks with a wipe. LN H doffed her left glove then donned a new glove; no hand hygiene performed. She cleansed R16's sacral wound with normal saline soaked gauze, R16 became agitated and laid back on her bed, contaminating her wound. CNA M rolled R16 back on her right side while LN H doffed her right glove and donned a new glove, no hand hygiene was performed. LN H opened R16's bedside table drawer and pulled out a package of cotton applicators. She removed a cotton applicator from the package and put Therahoney (medical-grade honey) gel on the applicator then applied it to R16's sacral wound. R16 continued to be agitated and laid back on her bed, contaminating the wound again. CNA M rolled R16 on her right side again while LN H placed a bordered dressing on the sacral wound. LN H did not apply skin-prep to periwound. LN H doffed her gloves then donned new gloves without performing hand hygiene. She removed the soiled dressing from R16's left lateral ankle then cleansed the wound with normal saline soaked gauze. She doffed her gloves then donned new gloves without performing hand hygiene, applied skin-prep to periwound of the left ankle then placed a bordered gauze dressing. LN H doffed her gloves and donned new gloves without performing hand hygiene. She poured normal saline in a cup with gauze. Both LN H and CNA M rolled R16 to her left side for better access to her right buttock wound. LN H used a wipe to cleanse her buttock then doffed gloves and donned new gloves without performing hand hygiene. LN H cleansed the right buttock wound with normal saline soaked gauze, patted the area dry, then placed Therahoney gel on a cotton applicator and applied it to the wound. She placed a bordered gauze dressing; she did not apply skin-prep to periwound. LN H doffed her gloves and performed hand hygiene, doffed her gown, no hand hygiene performed, touched the dressing supplies in the bin and drawers, donned gloves, removed the trash, then performed hand hygiene. On 03/29/23 at 02:02 PM, LN G stated cross-contamination was prevented during dressing changes by changing gloves and performing hand hygiene. She stated if a resident laid on the wound after it was cleansed, it was considered dirty again. LN G stated when going from a soiled to a clean area, gloves were removed, and hand hygiene was performed before putting on new gloves. She stated the nurse knew what the dressing change order was by looking on the Treatment Administration Record (TAR) and if the order called for skin-prep, it was expected to be done. LN G stated the nurses were responsible for completing dressing changes and were to be done on their shift and if it was not completed, the nurse let the oncoming shift know so it was completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/23 at 02:52 PM, Administrative Nurse D stated cross-contamination was prevented during wound care by using a clean surface, remembering which was the clean hand and which was the dirty hand, and sanitizing after removing gloves. She stated if the wound touched the bed again, the process was started over. Administrative Nurse D stated dressing orders were located on the TAR and if skin-prep was ordered, then it should have been done. She stated nurses were expected to complete dressing orders when scheduled. The facility's Skin and Pressure Injury Prevention policy, last revised 03/13/23, directed the facility assessed residents for risk in the development of pressure injuries and implemented preventative measures in accordance with current standards of practice. The policy did not address following wound care orders or preventing cross-contamination during wound care. The facility's Infection Control policy, last revised November 2019, directed all personnel were trained on infection control polices and practices upon hire and periodically, including where and how to find and use pertinent procedures and equipment related to infection control. The policy objectives included maintaining a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. The facility failed to follow wound care orders and prevent cross-contamination during wound care for R16. This deficient practice had the risk for delayed wound healing and unwarranted physical complications for R16.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 111 residents. The sample included 14 residents with two reviewed for accident hazards. Based on observation, interviews, and record review the facility failed to ensure adequate staff to provide supervision to resident (R) 1, and failed to ensure R2's wheelchair was functional and safe to sue. This deficient practice placed the residents at risk for avoidable falls, and related injuries. Findings included: - The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of heart disease, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), anxiety disorder major depressive disorder (major mood disorder), osteoarthritis (degenerative changes to one or many joints characterized by swelling and), cerebral infarction (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), seizure (violent involuntary series of contractions of a group of muscles), emphysema (long-term, progressive disease of the lungs characterized by shortness of breath), and dementia (progressive mental disorder characterized by failing memory, confusion). R1's Quarterly Minimum Data Set (MDS) indicated that a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated that R1 required extensive assistance from one staff member for bed mobility, transfers, and toileting. The MDS indicated that R1 was not steady during transfers from surface to surface and required staff assistance. The MDS indicated R1 had no falls since his admission. A review of R1's Dementia Care Area Assessment (CAA) completed 04/08/22 indicated R1 had a cognitive decline related to his dementia diagnosis. The CAA instructed staff to monitor him for behavioral and cognitive changes. A review of R1's Falls CAA completed 04/08/22 indicated that R1 had a history of falls. The CAA noted he frequently doesn't realize he needs to call for help with transfer and will attempt to transfer without assistance leading to falls. A review of R1's Care Plan initiated 06/16/19 indicated the R1 had a history of falls related to decreased mobility, weakness, hypotension, loss of balance, and not locking his wheelchair. The care plan noted for staff to anticipate his needs (10/09/19), apply skid strips to the floor (09/06/22), ensure his light is within reach (10/09/19), wear non-skid socks (12/06/20), increased rounding during the night (03/19/21), keep wheelchair next to bed (4/6/22), and keep bed in the lowest position (01/23/22). On 02/05/23 the care plan noted a fall occurred. The intervention for the fall again instructed staff to increase rounding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R1's EMR under Nursing Documentation on 02/05/23 at 05:00AM indicated R1 was found on the floor of his room at 03:12AM next to his bed. The note indicated that his wheelchair was next to his bed. The report noted that he was assisted to his wheelchair and moved to the nurse's station. The note indicated that the medical provider and resident representative were notified on the fall. The note indicated that no injuries or skin alterations found. A review of a facility provided Incident Report for the fall on 02/05/23 at 03:12AM noted a root cause of the fall occurred when R1 attempted to transfer himself without staff assistance or using his call light. The note indicated that neurological, range of motion, and pain assessments revealed no concerns. The report noted factors contributing to his fall were impaired cognition and poor safety awareness. A review of the facility's staffing records, timecards, and working schedules for the date and hours preceding, during and immediately after the fall revealed no licensed nurses in the facility on 02/05/23 from 12:20AM through approximately 04:00AM to respond to R1's fall that occurred at 03:12AM. The facility additionally only had four direct care staff to assist with the 111 residents in the facility during this timeframe, with two assigned to R1's unit. On 02/07/23 at 09:10AM R1 lay in his bed with his oxygen tubing cannula in place. R1's bed was in the lowest position. His wheelchair was next to his bed and his call light in his hand. R1 reported he could not remember his fall or what caused the fall. R1 denied pain or concerns. On 02/07/23 at 03:38PM Administrative Nurse E stated that on 02/05 she was called in to work at 04:00AM to be the licensed nurse in the facility. She acknowledged that the facility had no licensed nurse coverage when the fall occurred, and things could go wrong if no nurses are in the facility to care for the residents. She stated that she was contacted about the fall and completed and assessment over the phone with R1. She stated that the facility acuity of the residents is not safe for the level of care the residents required. On 02/08/23 at 03:00PM in an interview with Certified Medication Aid (CMA) R stated that R1 often can transfer easily with assist but forgets his limitation and will not ask for staff assistance. He stated that R1 was a fall risk and should always be assisted with transfers. He stated that the facility recently has been struggling with staffing and often will be understaffed. He stated that the staffing issues affect resident cares and puts the residents at risk for things like falls. He stated that R1 was at a risk for falls. He stated that if a resident falls the direct care staff should immediately notify the nurse on duty. He stated that staff should never move or reposition the resident until the nurse has assessed the resident and instructed staff to do so. He stated that all staff involved should complete witness statements for the fall. On 02/08/23 at 03:23PM Licensed Nurse (LN) L stated that R1 was a fall risk due to no understanding his limitation at times. He stated that R1 does easily transfer but required limited assistance from staff. LN I stated that the facility struggled with staffing and has worked before about six or seven times as the only nurse on the floor. He stated low staffing often affects the cares the residents receive. He acknowledged that be understaffed is not safe for the residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Staffing revise 04/2019 indicated that the facility will maintain adequate staff to meet the needs and services of the resident population. The policy noted that licensed nurse and direct care staff will be available on each shift to provide and monitor delivery of each resident's care as outlined on the resident's comprehensive care plan. The facility failed to ensure adequate staff rounding and supervision to pervent falls and accidents for R1 resulting in a non-injury fall. This deficient practice placed R1 at risk for preventable falls and injuries. (See F725) - The Medical Diagnosis section within R2's Electronic Medical Records (EMR) included diagnoses of chronic respiratory failure, heart failure, acute kidney failure, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cerebral infarction (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), diabetic foot ulcer (slow-healing wound that commonly appears on the feet), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). R2'S Quarterly Minimum Data Set (MDS) dated [DATE] indicated that a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that she required limited assistance from one staff for transfers, bed mobility, and toileting. The MDS noted that she had frequent pain and received scheduled pain medication as needed. The MDS noted that R2 had no falls since admission. The MDS indicated R2 used a wheelchair for mobility. A review of R2's Activities of daily Living (ADLs) Care Area Assessment (CAA) completed 10/24/22 indicated she required supervision with most ADLs due to her diabetic ulcer on her left foot. The CAA indicated that she was non weight bearing on her left foot. A review of R2's Falls CAA completed 10/24/22 noted that she had no falls since her admission but remained a fall risk due to her medical diagnoses, impaired mobility, medication, and foot ulcer. A review of R2's Pain CAA completed 10/24/22 noted that she had complaints of pain related to her left foot ulceration. The CAA indicated that she received oxycodone (medication used to treat moderate to severe pain) routine and as needed. R2's Care Plan for Falls initiated 10/18/22 noted R2 was at risk for falls related to her medical diagnoses, history of falls, and balance/gait problems. The plan indicated that staff should anticipate her needs , encourage strengthening and mobility activities, provide toileting assistance, and receive a physical therapy evaluation. The facility was unable to provide evidence of wheelchair auditsor maintenance checks as requested on 02/08/23. A review of the facility's Maintenance request revealed an order on 12/01/22 for R2's wheelchair. The work order noted requested for R2's breaks to be tightened related to one of the wheel moving while she attempted to stand. A Maintenance work order completed on 02/01/22 indicated that her wheelchair locks again needed adjustment after R2's fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R2's EMR under Nursing Documentation reviewed an evaluation on 02/01/23 indicating the nurse responded to a loud boom and found R2 lying face down on the floor near her closet. The note indicated that the top of her head hit the bottom of the closet. The note indicated that R2 reported that the right side of her wheelchair did not lock appropriately. The note indicated a maintenance order was placed and her wheelchair now locks correctly. On 02/07/23 at 09:25AM R2 reported that she has had multiple complaints about the brakes not functioning on her wheelchair. She reported that the brakes caused her to fall due to not being able to correctly tightened. On 02/07/23 at 03:45PM Licensed Nurse H reported that he found R2 on the floor during her fall. He reported that her right-side wheelchair locked did not lock correctly causing the wheel to move when she tried to stand up. He stated that she was sent to an acute medical center and returned the same day. He stated that he placed a work order to have the brakes fixed. On 02/08/23 at 02:20PM R2's representative reported that R2 had continual issues with her wheelchair's lock. She stated that the facility failed to tell her the cause of the fall until R2 had already been transported out. On 02/08/23 at 02:45PM Consultant JJ reported that all the resident's medical devices were audited monthly by the therapy staff to ensure the residents are safe. She reported that if any issues or concerns are found with the devices a maintenance order would be completed. On 02/08/23 at 01:23 Maintenance Staff U reported that he has worked on R2's wheelchair multiple times related to reports of her brakes not locking properly. He stated that the brakes were too tight and then adjusted to be too loose. A review of the facility's Fall Management and Prevention revised 11/2019 indicated that all factors of falls will be assessed for each resident to reduce the risk factors of the resident. The policy noted that therapy will evaluate each resident with risk related to gait, balance medications, medical devices, and safety. The facility failed to ensure R2's wheelchair remained in safe working condition resulting in a fall due to the brakes not locking properly. The deficient practice placed R2 at risk for preventable falls and injuries.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45668 The facility identified a census of 111 residents. The sample included 14 residents. Based on observation, record review, and interviews the facility failed to ensure that Resident (R)6, R7, R8, and R11, who required enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew or swallow food) received the physician ordered nutrition as prescribed. This deficient practice placed these four residents at risk for improper nutritional intake and possible weight loss. Findings included: - R6 had a diagnosis of gastrostomy (:a surgical creation of an artificial opening into the stomach thru the abdominal wall) and dysphagia (difficulty swallowing). R6 required enteral nutrition. Staff was directed to administer medications as ordered. Staff was to monitor/document for side effects and effectiveness. R6 had a physician's order dated 01/17/23 to administer 60 milliliters (ml) of water via gastrostomy tube (g-tube a tube placed into the stomach used for delivery of enteral nutrition) every six hours. The February 2023 Medication Administration Record (MAR) noted that R6 did not receive the enteral feed as ordered on three occasions 02/02/23 (early), 02/04/23 (7 PM-10PM), and 02/05/23 (early). R7 had a diagnosis of dysphagia. Staff was directed to give diet and consistency as ordered, two-Cal HN (a calorie and protein dense nutrition to support people with volume and intolerance and/or fluid restriction) bolus one can four times a day, flush with 275ml of water four times daily, and flush with 60ml of before and after feeding. R7 had an order dated 02/01/23 for enteral feeding three times a day two-cal HN through the percutaneous endoscopic gastrostomy (PEG-the placement of a feeding tube through the skin and the stomach wall). Review of R8's February 2023 MAR revealed that R7 was not administered the two-cal as ordered on 02/04/23 (7 PM- 10PM) and 02/05/23 (4 PM - 6 PM). R8 had a diagnosis of dysphagia. Staff was directed to administer tube feeding and water flushes per registered dietician recommendation and physician orders. A physician's order dated 01/25/23 for Jevity 1.2 (a high-protein fiber fortified therapeutic nutrition used for tube feeding) give through jejunostomy tube at a rate of 45 ml per hour continuous every day and night shift. Review of R8's February 2023 MAR revealed was not administered the Jevity on 02/04/23 (night). R11 had diagnoses of dysphagia, and protein-calorie malnutrition (inadequate intake of food). R11 required enteral tube feeding. Staff was to administer tube feeding and water flushes per dietician recommendations and physician orders. A physician's order dated 12/26/22 for Two-Cal via tube bolus 355ml to be administered four times daily. A review of the February 2023 MAR revealed R11 did not receive his ordered Two-Cal on 02/04/23 (7PM-10PM dose) and 02/05/23 (4PM- 6PM dose). On 02/08/23 at 03:54 PM Administrative Nurse D stated these residents did not receive their scheduled enteral feeding due to not having enough staff on duty to administer the medication at those times. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Review policy revised August 2019 documented: Licensed nurses must ensure that prior to the end of their shift all medications/treatments administered/refused/held are properly documented on the MAR and all treatments completed/refused/held are properly documented on the Treatment Administration Report (TAR). Failure to do so was considered an omission in the medical record. When the medication pass was complete, the nurse was to recheck the MAR to make sure all medications have been administered and documented appropriately. The nurse will follow up and document appropriately on medications that were administered but not documented. The facility failed to ensure that staff administered physician ordered enteral nutrition feedings for R6, R7, R8, and R11, which placed these residents at risk for improper nutritional intake and possible weight loss. (Refer to F725)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 111 residents. The sample include 14 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to consistently provide tracheostomy care to Resident (R)4. The facility additionally failed to investigate and document the repeated dislodgment her tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted) tube. This deficient practice placed R4 at risk for respiratory illness and related complications. Findings Included: - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of persistent vegetative state (disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness), acute respiratory failure, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anoxic brain damage (complete lack of oxygen to the brain), tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted), gastrostomy (surgical creation of an artificial opening into the stomach thru the abdominal wall), and stiffness of joints. R4's Annual Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated R4 was totally dependent on two staff members for mobility, transfers, bathing, dressing, locomotion, toileting, and personal hygiene. The MDS noted she had a feeding tube and tracheostomy. The MDS indicated R4 had no falls since admission. A review of R4's Activities of Daily Living (ADLs) Care Area Assessment (CAA) completed 08/21/22 indicated that due to her medical diagnoses she was dependent on staff for all ADLs. The CAA noted that all nutrients are provided via her feeding tube. The CAA noted that she used a Broda chair (specialized wheelchair with the ability to tilt and recline) when not in bed. R4's Care Plan for ADLs initiated 12/11/19 indicated that she required total dependence for assistance from two staff all ADLs except meals. The care plan noted she required a Hoyer (full body lift) lift for transfers. The care plan noted that resident does not participate in bed mobility or transfers and cannot assist herself with rolling on or off lift sheets during transfers. R4's Care Plan for Respiratory Care initiated 12/11/19 indicated that she had a tracheostomy. The plan indicated that staff should perform tracheostomy care daily and as needed using aseptic technique (12/11/19) The plan instructed staff to monitor R4 for signs of aspiration, fever, shortness of breath, tube dislodgment or dysfunction, or abnormal breathing sounds (12/11/19). The plan instructed nursing staff to monitor the humidifier, stoma (surgically created opening of an internal organ on the surface of the body) site, and to provide supplemental oxygen as necessary (12/11/19). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R4's EMR revealed a Self- Care and Mobility evaluation dated 10/25/22 noted R4 was dependent on staff assistance for mobility movements including transitioning from sitting to lying positions, lying to sitting on side of bed, toileting transfers, and toileting hygiene. The evaluation noted that walking, chair to chair transfers, and sit to stand transitions were not attempted due to medical/safety concerns. A review of R4's EMR under Change of Condition note indicated upon entering the nurse observed R4's tracheotomy tube pulled out and lying on her chest. R4 was sent to an acute care facility for placement. The EMR lacked documentation investigating the cause of the dislodgement. A review of R4's EMR under Nursing Clinical Evaluation dated 01/01/23 indicated upon entering the nurse observed R4's tracheotomy tube pulled out and lying on her chest. R4 was sent to an acute care facility for placement. The EMR lacked documentation investigating the cause of the dislodgement. A review of R4's Medication Administration Report (MAR) under Tracheostomy care orders revealed that R4 did not receive scheduled trach care, suctioning, oxygen therapy, or tracheostomy site assessment on the evening of 02/04/23. A review of R4's Medication Administration Report (MAR) indicated her evening pain assessment was not completed on the evening of 02/04/23. On 02/08/23 at 01:42PM R4 was in her bed. R4's bed contained a concave mattress and in the lowest position. R4 awake but not responsive to questions. R4's television was on but she was facing the room's window. R4's tracheostomy was intact. On 02/08/23 at 03:35PM Licensed Nurse (LN) L stated that R4 was a total care resident hat required assistance for all of her ADLs. He stated she can't move on her own without assistance from staff. He stated that staffing was an ongoing concern for the facility. LN L noted that staff often call off a lot and leave the residents of the facility without the proper care at times. He stated that he has been the only nurse working short staffed on about seven or eight occasions. He stated that basic cares and tasks often will not be completed due to the acuity and high census of the resident when staff call off or don't show up to work. On 02/08/23 at 02:24PM in an interview with Licensed Nurse (LN) I, stated that she worked the evening of 02/04/23. She stated tracheostomy cares were not completed due to not having enough staff to safety monitor all the residents in the facility. On 02/07/23 at 03:38PM Administrative Nurse E stated that the facility only had one nurse one nurse working the hallways on the evening of 02/04/23. A review of the facility's Tracheostomy Care policy revised 10/2014 noted that routine care is essential to ensure airway patency from mucus buildup, maintain skin integrity, prevent infections, and to provide psychological support. The facility failed to consistently provide tracheostomy care to R4. The facility additionally failed to investigate and document the repeated dislodgment her tracheotomy tube. This deficient practice placed R4 at risk for respiratory illness and decreased psychosocial well-being. (See F725)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 111 residents. The sample included 14 residents with two residents reviewed for pain management. Based on observation, record review and interview the facility failed to ensure staff provided effective pain management as ordered for Resident (R) 3 who received a scheduled opioid (a class of medication used to treat pain) and R2 who requested an as needed opioid for pain management. This deficient practice placed R3 and R2 at risk for uncontrolled pain and ineffective pain management. Findings included: - The electronic medical record (EMR) for R3 documented diagnosis of pain. The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented that R3 required extensive assistance of two staff members for activities of daily living (ADLs). The MDS documented a pain assessment for R3 revealed no pain was present during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R3 required supervision after setting up assistance for ADL's. The MDS documented a pain assessment was completed for R3, he had moderate pain during the look back period. The MDS documented R3 had received a scheduled and as needed pain medication during look back period. R3's ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 06/21/22 documented R3 required assistance with all ADL's. R3's Care Plan directed staff to administer medications as ordered. Staff was to evaluate the effectiveness of pain interventions as needed. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact of cognition. Monitor for signs/symptoms of pain with each interaction. If resident appears to be in pain utilize appropriate non-pharmacological and pharmacological interventions. Review of the EMR for R3 under the Orders tab revealed a physician order: Hydrocodone-acetaminophen tablet (opioid- used to treat pain) 5-325 milligrams (mg) give one tablet by mouth at bedtime for phantom pain dated 10/31/22 and discontinued 02/07/23. Review of the February 2023 Medication Administration Record (MAR) revealed R3 was administered his scheduled hydrocodone-acetaminophen 5-325 mg tablet as scheduled at bedtime on 02/04/23. Review of the narcotic control/count sheets for R3 lacked evidence the hydrocodone-acetaminophen tablet was administered on 02/04/23 as ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/08/23 at 01:26 PM R3 sat in a wheelchair the hallway outside his room. all. R3 stated on 02/04/22 the facility only had one nurse passing medication out for the entire building. R3 stated he had not received his scheduled pain medication as ordered by the physician. R3 stated the pain was related to his medical diagnoses and phantom pain from his amputation which he rated 8 out of 10 on the pain scale. R3 stated he had pain most of that night and could not sleep. On 02/08/23 at 03:36 PM Licensed Nurse (LN) I stated 02/04/23 was challenging because of the call-ins. She said residents do not get the care they need, and staff just tried to get done what they could. LN, I stated it was not safe when there was only one nurse in the building for 111 residents. On 02/08/23 at 3:54 PM Administrative Nurse D stated the facility just did not have enough staff on 02/04/23 so medication was missed and not given. The Pain Management policy last revised July 2019 documented: identify the potential cause for resident pain. Evaluate alleviating and/or exacerbating factors. Review effectiveness of past and current treatment, as well as specific spiritual and cultural issues related to pain. Determine appropriated interventions to manage pain and side effects. Appropriate interventions may include pharmacologic as well as non-pharmacologic interventions. The Medication Administration Review policy revised August 2019 documented: Licensed nurses must ensure that prior to the end of their shift all medications/treatments administered/refused/held are properly documented on the MAR and all treatments completed/refused/held are properly documented on the Treatment Administration Report (TAR). Failure to do so was considered an omission in the medical record. When the medication pass was complete, the nurse was to recheck the MAR to make sure all medications have been administered and documented appropriately. The nurse will follow up and document appropriately on medications that were administered but not documented. The facility failed to ensure that staff provided effective pain management for R3 when they failed to administer R3's schedule hydrocodone-acetaminophen on 02/04/22 at bedtime. This left R3 at risk for uncontrolled pain levels and ineffective pain management. (Refer to F725) 45668 -The Medical Diagnosis section within R2's Electronic Medical Records (EMR) included diagnoses of chronic respiratory failure, heart failure, acute kidney failure, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cerebral infarction (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), diabetic foot ulcer (slow-healing wound that commonly appears on the feet), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). R2'S Quarterly Minimum Data Set (MDS) dated [DATE] indicated that a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that she required limited assistance from one staff for transfers, bed mobility, and toileting. The MDS noted that she had frequent pain and received scheduled pain medication as needed. The MDS noted that R2 had no falls since admission. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R2's Activities of daily Living (ADLs) Care Area Assessment (CAA) completed 10/24/22 indicated she required supervision with most ADLs due to her diabetic ulcer on her left foot. The CAA indicated that she was non weight bearing on her left foot. A review of R2's Falls CAA completed 10/24/22 noted that she had no falls since her admission but remained a fall risk due to her medical diagnoses, impaired mobility, medication, and foot ulcer. A review of R2's Pain CAA completed 10/24/22 noted that she had complaints of pain related to her left foot ulceration. The CAA indicated that she received oxycodone (medication used to treat moderate to severe pain) routine and as needed. R2's Care Plan for Falls initiated 10/18/22 noted R2 was at risk for falls related to her medical diagnoses, history of falls, and balance/gait problems. The plan indicated that staff should anticipate her needs , encourage strengthening and mobility activities, provide toileting assistance, and receive a physical therapy evaluation. A review of R2's Medication Administration Record (MAR) revealed an order for her to receive oxycodone (opioid pain medication)five milligram (mg) with acetaminophen (325mg) every eight hours as needed for pain. The record revealed medication was not administered that evening. The record indicated that R2 had frequent moderate to severe pain daily. On 02/07/23 at 09:25AM in an interview with R2, she reported that she returned to the facility on [DATE] in the evening from an outing and asked for pain medication from nurse. R2 reported her pain rated that evening to be eight out of ten and told the nurse about her leg and her back issues. She reported that the nurse never came back to give her the medication. She stated that the nurse informed her that the facility was short on staff due to a nurse walking out. She stated that she could not sleep that evening and was told that the Certified Medication Aides (CMA) could not give her pain medication. On 02/08/23 at 02:24PM in an interview with Licensed Nurse (LN) I, stated that she worked the evening of 02/04/23. She stated that she could not pull R2's pain medications that evening because she did not feel comfortable pulling narcotic medication without a witness or having a proper staff information turnover for the residents. On 02/07/23 at 03:38PM Administrative Nurse E stated that the facility only had one nurse one nurse working the hallways on the evening of 02/04/23. She stated that the facility did not have a licensed nurse in the facility between 12:30AM to 04:00AM on the early morning of 02/05/23. A review of the facility's Medication Administration policy revised 12/2019 indicated all medication be given in a safe and timely manner. The policy noted that licensed or permitted persons will prepare, administer, and document that given as ordered within a reasonable timeframe. The facility failed to provide pain management for R2. This deficient practice placed R2 at risk for pain and decreased psychosocial wellbeing. (Refer to F725)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 111 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to ensure a licensed nurse was always on duty and in the facility 24 hours a day, seven days a week. On the early morning of 02/05/23, Licensed Nurse (LN) G was the only LN in the facility until she clocked out at 12:20 AM, leaving all resident without licensed nurse oversight. While there was no licensed nurse in the facility, Resident (R)1, who was severely cognitively impaired and a moderate risk for falls, had an unwitnessed non-injury fall around 03:15 AM. Additionally, during this period of time in which there was no licensed nurse staff in the facility, the facility had a census of at least 106, which included at least one resident with a tracheostomy (a surgically created hole [stoma] in the windpipe [trachea] that provides an alternative airway for breathing), five residents with gastronomy tubes (g-tubes, a tube surgically inserted into the stomach in order to introduce nutrients directly into the stomach) and more than 50 residents with full code status (desire for resuscitative measures in the event of inadequate respirations or cease of heartbeat). LN H arrived at the facility between 04:00 and 04:30 AM on the morning of 02/05/23 and then assumed care for all the residents. This deficient practice created an immediate jeopardy for all 111 residents presently in the facility. The facility further failed to ensure sufficient levels of nursing staff on duty in the facility to deliver care, assess, and provide physician ordered treatments and medications when the facility frequently staffed with just one licensed nurse to care for all the residents in the facility. This deficient staffing practice placed all 111 residents in the facility at risk for impaired health and wellbeing due to lack of adequate care. Findings included: - Review of the nursing schedule, daily posting hours, and timecard clock in and out times for 02/04/23 and 02/05/23 revealed the facility had no LN on duty and in the on 02/05/23 from 12:30 AM through 04:00 AM, three and a half hours. Review of the timecard clock times for 02/04/23 for licensed nursing staff revealed the following: LN H clocked in at 06:45 AM and left at 08:30 PM (12.75 overtime hours). LN J clocked in at 07:25 AM and clocked out at 07:21 PM (11.25 overtime hours). Administrative Nurse E clocked in at 08:22 AM and clocked out at 04:57 PM (8 regular hours). LN I clocked in at 07:14 AM and clocked out at 12:20 AM on 02/05/23 (16 regular hours). Review of the 02/05/23 timecard clock times for licensed staff revealed the first licensed nurse to arrive to the facility was LN G at 06:45 AM, followed by LN K at 07:12 AM, LN L at 07:23 AM and then LN J at 07:57 AM. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the schedule Topeka Center Saturday February 04 2023-Census 106 documented under the 07:00 PM to 07:00 AM (02/05/23) Administrative Nurse E from 04:30 AM to 07:00 AM and LN I from 07:00 PM to 12:30 AM. No other licensed nurse staff were listed. The Daily Staffing Sheet for posted nursing hours for 02/14/23 recorded a daily census of 114 and inaccurately recorded one registered nurse for 11.5 hours and one licensed practical nurse for 11.5 hours for the nightshift (07:00 PM to 07:00 AM). A notarized Witness Statement from Administrative Staff C (non-nursing personnel) documented on the evening of 02/04/23 at approximately 11:20 PM, Administrative Staff C received a call from the facility scheduler reporting a nurse had left the facility, and the nurse in the building needed to leave, which would leave the facility with no nurse in the building. The statement noted the scheduler had called everyone, but no one would answer. Administrative Staff C told the scheduler she would go to the facility if the scheduler would continue trying to reach someone. Administrative Staff C noted she arrived at the facility at around midnight. Administrative Staff C tried to reach Administrative Nurse F (the Director of Nursing [DON] at the time of the incident) multiple times with no answer. Administrative Staff C noted she went to the facility to provide moral support, help get drinks, and to keep the staff focused. Administrative Staff C noted that around 03:00 AM to 03:30 AM, a resident (R1) fell . Administrative Staff C was informed by the medication aid (Certified Medication Aid [CMA] T). Administrative Staff C again made several calls with no answer until she called Administrative Nurse E, who said she would come into the facility. The statement recorded staff assured the resident was in no pain when moving his arms and legs. Administrative Staff C asked the (unidentified) aides to get vital signs and get R1 into his chair; staff then took R1 to the nurse's station so staff could observe him until a nurse, Administrative Nurse E, arrived at the facility. Administrative Staff C documented Administrative Nurse E arrived at the facility between 04:00 AM and 04:30 AM that morning (02/05/23). R1's Electronic Medical Record under Nursing Documentation on 02/05/23 at 05:00AM indicated staff found R1 on the floor of his room next to his bed at 03:12 AM. The note indicated that his wheelchair was next to his bed. The note documented staff assisted R1 to his wheelchair and moved R1 to the nurse's station. The staff notified the medical provider and resident representative of the fall. The note indicated staff found no injuries or skin alterations on R1. (See F689) Review of the EMR revealed over 50 residents in the facility at the time of the incident had a Full Code status. Review of the Centers for Medicare and Medicaid Services (CMS) Resident Census and Conditions of Residents form printed 02/08/23 revealed the following: Five residents who received dialysis (a process of purifying the blood of a person whose kidneys are not working normally). One resident who received intravenous therapy (medication and/or fluids administered directly into the blood stream via a vein). Eighteen residents who received respiratory therapy; two residents who required suctioning. One resident with a tracheostomy. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Five residents with a g-tube who received tube feedings (liquid nutrition given through a tube) Review of the facility provided lists identified five residents who required continuous positive airway pressure (CPAP- a machine that uses mild air pressure to keep breathing airways open while you sleep) or bilevel positive airway pressure (BiPAP- a machine used to treat conditions in which a person needs assistance breathing); one resident with a wound vac (vacuum pump which helps wounds heal by decreasing air pressure around the wound), and 52 diabetic (a health condition which requires monitoring and often medication in order to control blood sugar levels) residents. On 02/07/23 at 09:25AM in an interview with R2, she reported she returned to the facility on [DATE] in the evening from an outing and asked for pain medication from the nurse. R2 reported her pain rated that evening to be eight out of ten and told the nurse about her leg and her back issues. She reported a nurse never came back to give her the medication. She said the staff informed her that the facility was short on staff due to a nurse walking out. She stated she could not sleep that evening and was told that the CMA could not give her pain medication. On 02/07/23 at 03:38PM Administrative Nurse E stated that she was contacted on 02/04/23 and informed that a nurse had walked out of the facility and the facility had no replacement nurse. She stated she had already worked the day shift that day and could not cover the open shift. She stated she did not know when LN I left the facility but reported she was contacted by Administrative Staff C at 03:30AM regarding a fall in the facility. Administrative Nurse E stated that the facility had no licensed nurse from 12:30AM on 02/05/23 until she arrived at between 04:00 AM and 04:30 AM on 02/05/23. She stated that not having a licensed nurse in the facility was dangerous for the residents and could lead to a potentially, very serious, negative outcomes. On 02/07/23 at 05:00 PM, Consultant KK acknowledged the facility was without a licensed nurse for several hours on the early morning of 02/05/23. Consultant KK reported the facility had started education and notified the provider (Medical Director) and began discussing a plan to prevent reoccurrence. Consultant KK identified the root cause of the issue was the unavailability of the on-call staff, primarily Administrative Nurse F, who was no longer employed by the facility. On 02/08/23 at 02:24PM in an interview with Agency LN I, she stated she left the facility shortly after midnight on 02/05/23. She stated she left when Administrative Staff C arrived though she knew the staff member was not a nurse. She stated she questioned Administrative Staff C about leaving without a nurse replacement and Administrative Staff C told her the state regulations prohibited a nurse from working more than 16 hours. The facility's Staffing Hours policy dated April 2019 documented the facility would provide adequate staffing to meet the needed care and services for the resident population. The facility would maintain adequate licensed registered nursing and licensed nursing staff would be available to provide and monitor the delivery of the resident care services. The facility failed to ensure a licensed nurse was always on duty and in the facility 24 hours a day, seven days a week. This deficient practice created the likelihood for resident injury and/or impaired health and safety due to the lack of licensed nurse supervision which placed all residents in the facility in immediate jeopardy. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/08/23 the facility submitted an acceptable plan to remove the immediacy which included the following actions: All residents were assessed by administrative nursing staff, and vital signs measured. Medication reports were reviewed to identify residents who had missed treatments or medications and those residents were evaluated specifically for negative outcomes related to the missed administration. The resident with the fall was assesses and ongoing evaluations continued. Social services staff interviewed alert and oriented residents to determine psychosocial impact. The facility schedules were reviewed to ensure adequate nursing staff scheduled to and the presence of licensed nursing staff 24 hours a day. The nurse management team and staffing coordinator were educated to ensure the facility always has a licensed nurse on duty in the facility. The facility developed an on-call schedule for nursing administration to ensure the requirement for a licensed nurse is adhered to. Nurse managers will do shift on-call rotation to come in and cover staffing call out or emergencies. All alternatives will be contacted to see who is available to cover shifts and supplemental bonuses established in that event. The Staffing Coordinator was educated to ensure adequate staffing levels and who to notify if staffing levels inadequate. The Staffing Coordinator will review the daily staffing with facility administrative staff, to include nursing, to ensure adequate staff coverage is adhered to. The State Agency verified the removal of the immediacy on 02/08/23 at 10:00 AM. The scope and severity of the deficient practice remained at an F. - Review of the working schedule form revealed the facility identified the need for three licensed nurses (LN) and six certified nurse aides (CNA) on the overnight shift with a listed census of 106. Review of the daily posted staffing sheets from 01/01/23 through 02/07/23 revealed four occasions when there was only one LN for the overnight shift: 01/02/23, 01/03/23, 01/05/23,01/09/23 and revealed less than the required three on 14 occasions (January 1,4,10,11,15,16,17,22,23,24,25, and 30 and February 04, and 06) Review of the working schedules from 01/01/23 through 02/07/23 revealed only one LN scheduled on the nightshift on 01/03/23,01/05/23, 01/09/23 and 01/30/23. Review of the timecard clock times for 02/04/23 revealed there was one Agency LN, LN I, from 08:30 PM until LN I left at 12:20 AM leaving the facility with no LN until Administrative Nurse E arrived between 04:00AM and 4:30 AM. Administrative Nurse E was the only nurse present until LN H arrived at 06:45 AM. Review of the Electronic Medical Records (EMR) for Residents (R) 2 and R3 revealed pain medication was not administered to both residents on the evening/night shift of 02/04/23. Both residents reported pain during this timeframe. Additionally, a pain assessment was not completed on R4. (See F697 and F600) Review of the EMR for R4 revealed that tracheostomy care was not completed on the evening shift of 02/04/23. (See F695) Review of the EMR for R6, R7, R8, and R11 revealed the residents did not receive their scheduled tube feeding during the evening/night shift with only one nurse present. (See F693) (continued on next page)

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	175172	A. Building B. Wing	02/08/2023

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Excel Healthcare and Rehab Topeka	2515 SW Wanamaker Road Topeka, KS 66614

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the EMR for R8 who had diabetes mellitus (a health condition which requires monitoring and often medication to control blood sugar levels) revealed R8 did not receive his insulin (hormone administered via injection to control blood sugar levels) on the evening shift of 02/04/23. (See F684) On 02/08/23 at 01:26 PM R3 sat in a wheelchair in the hallway outside his room. R3 stated on 02/04/22 the facility only had one nurse for the entire building. R3 stated he had not received his scheduled pain medication as ordered by the physician. R3 stated the pain was related to his medical diagnoses and phantom pain from his amputation which he rated 8 out of 10 on the pain scale. R3 stated he had pain most of that night and could not sleep. On 02/07/23 at 03:38 PM Administrative Nurse E confirmed the one nurse scheduled to work the evening/overnight shift on 02/04/23 did not work that evening because the nurse became aware there was only one nurse scheduled, and that nurse did not desire to work unsafely, under those circumstances. She stated she worked the day shift on 02/04/23 because there was only one nurse on the North unit, an agency nurse, who was there for her first time and there was too much work for just one nurse. Administrative Nurse E stated the administrative nurses do not have much authority or say in the schedule and said she did not know if the facility considered resident acuity when determining staffing levels. On 02/07/23 at 04:07 PM LN H stated he worked at the facility as a traveling nurse and reported he enjoyed the work and taking care of the residents. He reported there have been occasions where there was only one nurse on the night shift and further said that weekends were very difficult due to low staffing and call ins. LN H stated the facility has challenging residents that require a lot of care, including behavioral residents and residents with feeding tubes and tracheostomies. LN H confirmed if there not enough staff, the treatments, and medications were not always administered as ordered. On 02/08/23 during the onsite survey, a nursing staff member who wished to remain totally anonymous reported there was not enough staff overnight to ensure the residents received good care. The staff reported there were several residents that required a full body lift and two staff for transfers, and multiple residents that required heavy cares. The staff reported that nursing staff struggled to provide the basic cares for the residents but went on to say staff did not have enough time to complete other task such as cleaning, changing of respiratory tubing and feeding equipment, cleaning of wheelchairs and other tasks. The staff reported that all staff were busy with providing just the most basic of care and if a resident needed psychosocial support, or emotional support, the staff were too busy to provide that kind of care. The staff also reported that if there was only one nurse in the building, and a resident fell or required resuscitation, one nurse would not be enough to provide the emergency care and care for the other residents. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/08/23 at 02:24 PM in an interview with LN I, she stated she was the only nurse on duty after the South unit nurses left on 02/04/23. She stated the North unit was too busy for just one nurse, let alone the whole building. She reported she had one resident on the North unit who required intravenous (given through a vein directly into the bloodstream) antibiotics which she administered but reported she did not know there was a resident with a tracheostomy because she was running back and forth between both sides, as well as trying to locate equipment to care for a residents colostomy (a surgical opening to drain feces into an external pouch). LN I reported she attempted to prioritize the cares and respond to urgent needs however, there was too many treatment and medication for one nurse to accomplish. She stated she felt having one nurse for the over 100 residents in that facility was incredibly unsafe. On 02/08/23 at 03:35 PM, LN G reported he did not feel safe being the only nurse in the facility. He reported he was put in that position many times by the facility and would not do it again. LN G reported he had worked many years at the facility and knew the residents well but did not think it was safe for the residents to have only one nurse. LN G reported when the facility was short on staff, the staff tried to do the best they could but things such as treatments did not always get done. On 02/08/23 at 03:54 PM Administrative Nurse D stated the facility just did not have enough staff on 02/04/23 so medication was missed and not given. Administrative Nurse D stated staffing at the facility was an ongoing issue. She stated she was uncertain, but she thought the staff numbers were set, and did not account for resident acuity or condition. Administrative Nurse D confirmed that having one nurse in the facility, given the acuity of the residents, was not a safe or acceptable situation. The facility's Staffing Hours policy dated April 2019 documented the facility would provide adequate staffing to meet the needed care and services for the resident population. The facility would maintain adequate licensed registered nursing and licensed nursing staff would be available to provide and monitor the delivery of the resident care services. The facility failed to ensure adequate staffing levels in order to provide necessary treatment, care and medications to the residents and failed to ensure adequate staffing levels to support the residents' highest quality of life and psychosocial wellbeing.

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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. 41037 The facility identified a census of 111 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week. This placed all residents who resided in the facility at risk of lack of assessment and inappropriate care. Findings included: - Review of the nursing schedule, daily posted nursing hours and timecards of RN staff from 01/01/23 through 02/08/23. revealed a lack of RN coverage for eight consecutive hours a day, on the following dates: 01/09/23, 01/10/23, 01/16/23, and 01/28/23. On 02/08/23 at 03:36 PM Administrative Nurse D stated administration was responsible for licensed nurse staffing. Administrative Nurse D stated staffing had been a challenge because of call ins from the staff. Administrative Nurse D stated documentation and wound care are just some of the things that may not get completed, along with it was not safe for the resident's when the facility was not staffed. The facility's Staffing Hours policy dated April 2019 documented the facility would provide adequate staffing to meet the needed care and services for the resident population. The facility would maintain adequate licensed registered nursing and licensed nursing staff would be available to provide and monitor the delivery of the resident care services. The facility failed to provide Registered Nurse coverage eight consecutive hours a day, seven days a week, as required. This placed the residents who resided in the facility at risk of lack of assessment and inappropriate care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 111 residents. Based on observation, record review and interview the facility failed to ensure medications were stored and labeled appropriately when staff failed to lock an unattended medication cart, failed to discard expired insulin (a hormone that regulates blood sugar) and failed to ensure medications were stored properly on one medication cart. This deficient practice created the risk for ineffective medication regimen and medication errors and accidents. Findings included: - On [DATE] at 12:10 PM, a medication cart was on the South unit first hallway, unlocked and unattended. Review of the cart revealed the cart contained injectable medications and multiple bubble-pack medication cards as well as liquid for inhalation and powdered medication. Inspection of the cart revealed a medication cup in the top drawer, towards the back which contained two round white pills, one whole and one haled. The pill cup was open, and was not labeled with a date, resident name, medication name, dose, route, or any other required information. The cart contained one bubble- packed lisinopril (medication used to lower blood pressure) tablet which lacked a resident name, route or other required information. The cart contained the following outdated medications: One vial of insulin lispro (long-acting insulin) which had an open date of [DATE]. One insulin lispro insulin pen with an open date of [DATE]. One Levemir (long-acting insulin) with an open date of ,d+[DATE] (the actual day was illegible, but month and year were clear). In an interview on [DATE] at 12:21 PM Licensed Nurse (LN) H confirmed the cart should always be locked when unattended. LN H stated insulins were only good for a set amount of time once opened but he was unsure f the specific time frames for the individual types of insulin. He stated he would check and ensure all outdated insulins were removed from the cart. He stated medications should not be stored open, in a pill cup, inside the cart and disposed of the pills. Review of the instructions for insulin lispro at www.humalog.com revealed opened Humalog (insulin lispro) vials, prefilled pens, and cartridges must be thrown away 28 days after first use, even if they still contain insulin. Review of instructions for Levemir at https://www.novo-pi.com/levemir.pdf revealed Levemir pen is good for 42 days after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy Medication-Storage directed all medications will be stored in a locked cabinet or cart. Medications will be stored in the original, labeled containers received from the pharmacy. The facility failed to ensure medications were stored and labeled appropriately when staff failed to lock an unattended medication cart, failed to discard expired insulin, and failed to ensure medications were stored properly on one medication cart. This deficient practice created the risk for ineffective medication regimen and medication errors and accidents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45668 The facility identified a census of 111 residents with nine residents 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. Based on observation and interview, the facility failed to maintain a sanitary environment when staff failed to store clean linens appropriately and failed to remove open bags of trash and soiled items from the hallway. This placed the affected resident at increased risk of communicable diseases including CRAB. Findings included: - On 02/08/23 at 06:36 AM a facility tour revealed the following observations: Two very large trash bags which contained multiple smaller bags or trash sat open, and on the floor of the South unit first hallway. The trash bags contained resident care items such as soiled incontinence briefs, used personal hygiene wipes and soiled personal protective equipment. The smaller bags inside the large bag were also not all tied or closed. The bags emitted a strong urine odor. The South unit first hallway had a cart which had laundered, folded linens (towels, gowns, washcloths) on all three tiers sat uncovered directly outside and next to a room which had an isolation cart for contact precautions related to CRAB. The South unit middle hallway dining/common room which contained the vending machines had a trash can that was overflowing with trash. The trash flowed over onto the floor and contained multiple food and drinks wrappers, packages, and cups as well as other trash. An unidentified resident sat in the room at that time. R1's bedroom door had a used, unbagged nasal cannula (device placed in the nose to deliver supplemental oxygen) which had dried substance on it tied in a knot around the door handle. The North unit had a cart stacked with laundered, folded linens (towels, gowns, washcloths) which sat uncovered in the hallway outside a resident's room. There were other care items stored on the cart which included gloves, cups, and creams. On 02/08/23 at 03:13 PM Certified Nurse Aid (CNA) S stated the linens should be stored in the clean linen room and should be kept always covered. CNA S stated bags of trash should never be left on the floor in the hallways to prevent cross contamination. On 02/08/23 at 03:34 PM Licensed Nurse (LN) L stated clean linens should not be stored in the hallways and should always be covered. LN I said trash should remain in the residents' room until properly collected by staff and removed to the trash receptacle. On 02/08/23 at 04:00 PM Administrative Nurse D stated clean linens should remain covered and in a clean linen room and all soiled items included trash should be taken directly to the dumpster or to the soiled utility room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not provide a policy. The facility failed to maintain a sanitary environment when staff failed to store clean linens appropriately and failed to remove open bags of trash and soiled items from the hallway. This placed the affected resident at increased risk of communicable diseases including CRAB.