STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175176	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 48 residents. The sample included 16 residents with 16 reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Residents (R)25, R30, R39, and R40 received assistive cares in a dignified manner. This deficient practice placed the residents at risk for decreased psychosocial well-being. Findings Included: - The Medical Diagnosis section within R25's Electronic Medical Records (EMR) included diagnoses of traumatic brain injury, dementia (progressive mental disorder characterized by failing memory, confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and major depressive disorder (major mood disorder). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R25 required limited assistance of one staff member for activities of daily living (ADLs). A review of R25's Care Plan initiated 11/07/19 indicated that he received diabetic medication as order by his doctor. The plan instructed staff to monitor for effectiveness and side effects. On 02/13/23 at 09:10 AM Licensed Nurse (LN) K completed R25's morning glucose (blood sugar) checks and vital signs (blood pressure and heart rate) at the main dining room table while the resident consumed breakfast. On 02/14/23 at 08:38 AM LN J completed R25's morning glucose checks and vital signs at the main dining room table. On 02/16/23 at 12:35 PM, Certified Nurse Aide (CNA) M stated staff should ask permission from the residents before cares or assisting them. She stated she should not walk by a resident without greeting them and helping. On 02/16/23 at 04:00 PM, Licensed Nurse (LN) H stated that all the resident should be treated in a dignified manner including asking them for permission, creating privacy during cares provided, calling them by their preferred name, and treating them with dignity. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Resident Rights policy revised 12/2016 noted that the facility will ensure each resident has a dignified existence and be treated with respect. The policy noted staff will be supportive of the resident's needs, beliefs, and determinations. The facility failed to ensure R25 had privacy during a care procedure. This deficient practice placed R25 at risk for decreased psychosocial wellbeing. - The Medical Diagnosis section within R30's Electronic Medical Records (EMR) included diagnoses of alcohol induced dementia, bipolar disorder, and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R30's Significant Change Minimum Data Set (MDS) completed 12/08/22 noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated R30 had verbal behaviors directed towards others and himself. The MDS noted his behaviors significantly interfered with his care. The MDS noted that he had a history of rejecting care. The MDS noted he required extensive assistance from two staff for bed mobility, transfers, dressing, personal hygiene, toileting, and bathing. The MDS noted he required supervision and one-person physical assist from one staff member, and he required a wheelchair for mobility. The MDS indicated that he was receiving hospice services. A review of R30's Care Plan for Activities of Daily Living (ADLs) indicated that he required extensive assistance from one staff for bed mobility, transfers, toileting, personal hygiene, and bathing. On 02/15/23 at 09:43AM R30 sat in his Broda chair as the main nurse's station. R30 was using his hands to push his chair away from the wall and moaning. At 09:44AM Administrative Nurse F asked, What's wrong?, R30 responded he wanted to go to bed. She stated Okay, I"ll tell them and walked away. R30 remained at the nurse's station moaning but staff failed to stop and intervene. At 09:46AM an unidentified CNA passed R30 and he moaned at her. CNA responded with I just took you to the bathroom and walked away. At 09:50AM R30 informed staff he had to pee. Staff responded with C'mon, let's go. At 09:52AM staff wheeled R30 into his room. On 02/16/23 at 12:35PM, CNA M stated that staff should ask permission from the residents before cares or assisting them. She stated that she should not walk by a resident without greeting them and helping. On 02/16/23 at 04:00PM, Licensed Nurse (LN) H stated that all the resident should be treated in a dignified manner including asking them for permission, creating privacy during cares provided, calling them by their preferred name, and treating them with dignity. A review of the facility's Resident Rights policy revised 12/2016 noted that the facility will ensure each resident has a dignified existence and be treated with respect. The policy noted staff will be supportive of the resident's needs, beliefs, and determinations. The facility failed to promote dignity for R30. This deficient practice placed R30 at risk for decreased psychosocial wellbeing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Medical Diagnosis section within R39's Electronic Medical Records (EMR) included diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), dysphagia (swallowing difficulty), major depressive disorder, and anxiety disorder. R30's Quarterly Minimum Data Set (MDS) completed 12/08/22 noted a Brief Interview for Mental Status (BIMS) score of one indicating severe cognitive impairment. The MDS indicated that he required supervision with one-person physical assist for meals. A review of R39's Care Plan for ADLs initiated indicated R39 could feed himself for meals with staff set-up assistance. The plan noted that R39 was a high risk for weight loss and required a divided plate related to his diagnosis of dysphagia. The care plan indicated that he has a towel or napkin to protect his clothing during meals. On 02/14/23 at 08:31 AM R39 sat in the dining room eating his breakfast. An unidentified CNA staff approached him and started feeding him his food while standing next to him. The CNA continued to assist him while standing while going back and forth in between tables to help other residents. On 02/16/23 at 12:35 PM, CNA M stated that staff should ask permission from the residents before cares or assisting them. She stated that she should not walk by a resident without greeting them and helping. On 02/16/23 at 04:00 PM, Licensed Nurse (LN) H stated that all the resident should be treated in a dignified manner including asking them for permission, creating privacy during cares provided, calling them by their preferred name, and treating them with dignity. A review of the facility's Resident Rights policy revised 12/2016 noted that the facility will ensure each resident has a dignified existence and be treated with respect. The policy noted staff will be supportive of the resident's needs, beliefs, and determinations. The facility failed to ensure dignified assistance during breakfast for R39. This deficient practice placed R39 at risk for decreased psychosocial wellbeing. - The Medical Diagnosis section within R44's Electronic Medical Records (EMR) included diagnoses dementia, anxiety disorder, schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and morbid obesity (severely overweight). R44's Quarterly Minimum Data Set (MDS) completed 12/15/22 noted a Brief Interview for Mental Status (BIMS) score of two indicating severe cognitive impairment. The MDS noted she required extensive assistance from one staff for bed mobility, transfers, locomotion, toileting, personal hygiene, and bathing. A review of R44's Care Plan initiated 12/19/22 indicated that she required a safe environment. The care plan indicated staff should anticipate her needs and reinforce appropriate expression of her feelings. The plan instructed staff to discuss her behaviors, confusion, and reorient her as needed. On 02/13/23 at 07:15 R44 was in the dining room. R44 attempted to talk but Social Service X came up behind her and commanded R4 in a terse tone R4 to get out of their way. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/13/23 at 08:20AM R44 sat in her wheelchair in the dining room. Two unidentified staff members came up behind her talking. One staff member started pushing R44 without asking R44 if she wanted to leave. R44 put her feet down to stop them. The staff member pushing her stated pick your feet up, you're being lazy and continued to push her to her room. On 02/14/23 at 07:27AM R44 wheeled herself around the dining room. R44's blanket became trapped underneath the wheelchair and dragged behind her. R44 had a large cup of ice in her hand as she attempted to retrieve her blanket. Multiple staff walked by R44 as she struggled to pull her blanket out. R44 spilled the ice over herself and the floor. An unidentified staff came over and said, what did you do?' to R44. On 02/16/23 at 12:35PM, CNA M stated that staff should ask permission from the residents before cares or assisting them. She stated that she should not walk by a resident without greeting them and helping. On 02/16/23 at 04:00PM, Licensed Nurse (LN) H stated that all the resident should be treated in a dignified manner including asking them for permission, creating privacy during cares provided, calling them by their preferred name, and treating them with dignity. A review of the facility's Resident Rights policy revised 12/2016 noted that the facility will ensure each resident has a dignified existence and be treated with respect. The policy noted staff will be supportive of the resident's needs, beliefs, and determinations. The facility failed to promote dignity for R44. This deficient practice placed R44 at risk for decreased psychosocial wellbeing.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 41037 The facility identified a census of 48 residents. The sample included 16 residents. Based on record review, and interviews, the facility failed to facilitate and ensure the resident council was able to meet regularly, which placed the residents at risk for isolation and unmet concerns related to life in the facility. Findings included: - Record review of the Resident Council Meeting revealed the facility had no minutes or meetings for the months of August 2022, September 2022, October 2022, November 2022, and December 2022. On 02/14/23 at 03:27 PM Resident (R) 35 stated the Resident Council had not met on a regular basis since the activity director had quit. R35 stated the administrative team would try facilitating a meeting for the residents, but the meeting fell through and did not happen as planned. R35 stated it was getting better and the facility had been posting the time and date for the Resident Council meeting. On 02/16/23 at 12:45 PM Social Services X stated the activity director oversaw the resident council meetings and currently the facility was without an activity director. Social Services X stated he believed there had been some meeting missed. Social Services X stated the administrative team was attempting to help cover the job responsibilities. The facility's Resident Rights policy last revised December 2016 documented federal and state laws guaranteed certain basic rights to all residents of the facility. Those rights included the resident's right to: exercise his or her rights as a resident of the facility. The facility failed to ensure the resident council was able to meet at least monthly placing the residents at risk for unmet concerns.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 45668 The facility identified a census of 48 residents. The sample include 16 residents with five residents reviewed for resident funds. Based on observation, record review, and interviews, the facility failed provide ensure resident funds accounts were accessible 24 hours a day seven days a week. This deficient practice placed 30 residents at risk for decreased psychosocial wellbeing. Findings Included: -A review of the facility's Resident Funds accounts revealed 30 residents had active accounts with the facility. On 02/13/23 at 08:30 AM, Resident (R)12 reported that he had continual problems with accessing his funds from his facility trust account. He stated that he had gone to the business office and reported that he was unable to access his money on evenings and weekends. He stated that the only time residents had access to their accounts was when Administrative Staff C was in the facility. He stated that he can not access his money when she is not in the facility. R12 was not made aware of any other staff that handle finances. On 02/14/23 at 03:38 PM, Resident Council members R1 and R35 reported the only way residents could access their money in their trust accounts was through Administrative Staff C. They reported that they were only aware that money withdraws occurred when she was working. ON 02/14/23 at 11:43 AM, Certified Nurses Aide (CNA) M stated that she was not aware of who handles the residents accounts when the business office closes. She stated that Administrative Staff C took care of the residents' accounts. On 02/14/23 at 04:00 PM, Licensed Nurse (LN) G reported that he was unaware of how residents would access their facility accounts in the evenings and weekends. On 02/15/23 at 02:42 PM, Administrative Staff C reported that residents should have access to there funds through the weekend manager. She reported that she only worked business hours (Monday -Friday). She reported that an envelope was locked in the nurse's station medication cart lock box. On 02/16/23 at 12:45 PM Social Services X reported the resident could only access their facility account when Administrative Staff C was in the facility. A review of the facility's Deposit of Resident Funds policy revised 04/2017 indicated that funds held by the facility will be safeguarded. The policy noted the resident will have access to the fund of $50.00 or less within 24 hours or in excess of $50.00 within three business days. The facility failed to ensure resident funds accounts were accessible 24 hours a day seven days a week. This deficient practice placed 30 residents at risk for decreased psychosocial wellbeing.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 41037 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, and interviews, the facility failed to post names, addresses, and telephone numbers of all pertinent state agencies and advocacy groups in a manner accessible and understandable to residents and/or their representatives. Findings included: - Observation on 02/14/23 of the facility lacked posters or notifications of posted names, addresses, and telephone numbers of all pertinent state agencies and advocacy groups, available to residents, family members and legal representatives of residents as required. On 02/14/23 at 03:27 PM Resident (R) 35 stated the there was no posting of the state complaint hotline number available to call. On 02/16/23 at 12:45 PM Social Services X stated the Resident Rights poster was available for review of the residents. Social Services X stated he would investigate in getting the proper material and posting of the outside agencies. The facility's Resident Rights policy last revised December 2016 documented federal and state laws guaranteed certain basic rights to all residents of the facility. Those rights included the resident's right to: to communicate with outside agencies (e.g., local, or federal) regarding any matter. The facility failed to ensure required posting for state agency and advocacy groups were posted prominently and readily accessible area to residents and/or their representatives.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47834 The facility identified a census of 48 residents with 16 residents included in the sample. The facility identified two residents who discharged from Medicare Part A services. Based on interview and record review the facility failed to issue CMS (Center for Medicare/Medicaid Services) Skilled Nursing Facility Advance Beneficiary Notification (SNF ABN) form 10055 (the form used to notify Medicare A participants of potential financial liability when a Medicare Part A episode ends) and Notification of Medicare Non-Coverage (NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service) form 10123 which contained the required information for Resident (R) 9 and R4. This failure placed the residents at risk for decreased autonomy and impaired right to appeal. Findings included: - Review of R9's Electronic Medical Record (EMR) documented the Medicare Part A episode began on 01/12/23 and ended on 01/27/23. R9 remained in the facility for custodial care. The facility issued SNF ABN 10055 lacked an estimated cost for continued services. The facility issued NOMNC 10123 lacked the name and contact information of the Quality Improvement Organization (QIO) to appeal the decision of Medicare non-coverage. Review of R4's EMR documented the Medicare Part A episode began on 01/19/23 and ended on 02/10/23. R4 remained in the facility for custodial care. The facility issued SNF ABN 10055 lacked an estimated cost for continued services. The facility issued NOMNC 10123 lacked the name and contact information of the QIO to appeal the decision of Medicare non-coverage. On 02/15/23 at 03:13 PM Social Services X stated he was responsible for issuing the beneficiary notifications. He stated he always issued them at least three days in advance. Social Services X stated he was using the forms supplied by the facility and since he was very familiar with the content of each form, he had not specifically read the forms in use by the facility. Social Services X reviewed the forms and then verified the NOMNC forms did not contain the information for the resident or their representative to contact the QIO. He verified the SNF ABN forms were also preprinted and did not contain an actual dollar amount or estimate of cost. Social Services X stated there was no way for him to know how much it would cost but did acknowledge that the number would be at least the daily rate and acknowledged the cost (actual price) may make a difference in the residents' decision-making process. He stated he would find out the information and update the forms with the required information. The facility did not provide a policy on beneficiary notification. The facility failed to ensure the forms provided at the end of skilled services contained the required information for the residents to make informed choices and appeal the non-coverage decisions. This failure placed the residents at risk for decreased autonomy and impaired right to appeal.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45668 The facility identified a census of 48 residents. The sample include 16 residents. Based on observation, record review, and interviews, the facility failed to maintain a safe, homelike environment. This deficient practice had the potential for decreased psychosocial well-being and impaired safety and comfort for the residents. Findings Included: - On 02/13/23 at 07:25 AM during the initial tour, observation of Resident (R) 28's room revealed two large, dark brown spots on the floor which appeared to be dried spills. R28 sat in his wheelchair, leaned completely over and wiped at the spots with a Kleenex. R28 was unable to clean the spots with the dry Kleenex so he spit on the floor, onto the spot, and then proceeded to clean up the dried spills. The 100-hall had a very strong urine odor halfway down the hall to the end. On 02/13/23 at 08:03 AM an initial walk-through of the facility's locked unit revealed the unit's secondary dining room had broken blinds with cords dangling from the window area next to a table the residents' use. The plastic slats of the blinds were also broken off at the ends on both sides and hanging askew. The secondary dining room had a closet with sliding doors and one of the doors was off the tracks at the bottom and leaning at an angle creating an accident hazard. A room shared by two residents on the dementia unit was missing the wooden plaque that designated the room number and resident name consistent with the other rooms. The room number was written directly on the wall in black ink and the residents' names were written on tape and stuck on the wall. An inspection of cognitively impaired Resident (R)34's room revealed two long white coaxial (cable television) cords dangling down from the ceiling within reachable height of the resident in the room creating a potential danger. An inspection of the dementia unit's main dining room revealed a soiled and very stained dust curtain covering the activities cabinet. The dementia units dining room sink was very soiled with brown debris, dried, covered most of the sink basin. There was a large, coil of hair in the dining room sink. R9 and R28's bathroom smelled heavily of urine. In an interview with Certified Nurses Aide (CNA) M on 02/14/23 at 08:05 AM, she stated that a homelike environment means that the facility is taken care of, looks nice, and promote a healthy feeling for the residents. She stated that the environment should be safe and clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Licensed Nurse (LN) H on 02/16/23 at 11:45 AM, she stated the facility should maintain a homelike environment by keeping the facility clean, maintaining furniture, and allowing resident input. She stated broken equipment and furniture could be dangerous to the residents. A review of the facility's Homelike Environment policy revised 02/2021 indicated the facility would provide a persona centered care that emphasizes a safe, clean, and comfortable environment. The policy noted institutional odors should be minimized, rooms should be clean and sanitary. The facility failed to maintain a safe homelike environment. This deficient practice lead to decreased psychosocial well-being to the residents.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45668 The facility identified a census of 48 residents. The sample include 16 residents with three residents reviewed for abuse and neglect. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)30 remained free from staff to resident abuse, neglect, and mistreatment when Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) N each grabbed R30 by his hands, with his arms extended over his head, and drug him to position him on a mattress, which was on the floor next to R30's bed placed on the floor. CNA N placed a sheet over the resident, and both staff exited the room, turned the light out, and shut the resident's door despite the resident being awake and active, on the mattress on the floor. This deficient practice placed the resident in Immediate Jeopardy (IJ). Findings included: - The Medical Diagnosis section within R30's Electronic Medical Records (EMR) included diagnoses of alcohol induced dementia (progressive mental disorder characterized by failing memory, confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), muscle weakness, lack of coordination, restlessness, and agitation. R30's Significant Change Minimum Data Set (MDS) completed 12/08/22 noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated R30 had verbal behaviors directed towards others and himself. The MDS noted his behaviors significantly interfered with his care. The MDS noted that he had a history of rejecting care. The MDS noted he required extensive assistance from two staff for bed mobility, transfers, dressing, personal hygiene, toileting, and bathing. R30 required supervision and one-person physical assist from one staff member using a wheelchair for mobility. The MDS recorded R30 required maximal/substantial assistance with rolling from side to side, switching between lying to sitting, and transferring between bed and chair and he had a history of falls. A review of R30's Dementia Care Area Assessment (CAA) completed 12/08/22 indicated R30 had a diagnosis of dementia. The CAA noted he had a decreased ability to make himself understood, a decline in continence, and he needed assistance with his activities of daily living (ADL). A review of R30's Communication CAA completed 12/08/22 indicated he had impairments related to expression, reception of information, difficulty pronouncing and describing, and he had difficulty putting sentences together. A review of R30's Behavior CAA completed 12/08/22 indicated he had a history of rejection of care and verbal behaviors towards others. A review of R30's Falls CAA completed 12/08/22 indicated he was at risk for falls related to his medications and fall history. The CAA noted he utilized a wheelchair for mobility and was non-ambulatory. The CAA noted he would not always ask or accept staff assistance with transfers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R30's Care Plan initiated 09/09/19 for Cognitive Function indicated R30 had impaired cognitive function related to his medical diagnoses and impaired thought process. The plan noted he was at risk for abuse and instructed staff to approach him in a calm manner, address him by his name, and provide him personal space (11/05/20). The plan indicated R30 should be provided a home-like environment (07/19/21) A review of R30's Care Plan initiated 09/09/19 for Falls indicated he was at risk for falls related to his medical diagnoses, cognitive deficit, fall history, and behaviors. The plan noted a perimeter mattress was placed on his bed (10/10/22). On 12/02/22 an intervention was added for a non-injury fall, instructing he rolled off his bed onto the mattress on the floor. The care plan lacked documentation indicating why or when the mattress was place on the floor next to his bed. The plan instructed staff to place R30 in his Broda chair (specialized wheelchair with the ability to tilt and recline) when out of bed (01/16/23). R30's Care Plan lacked a preference to sleep on a mattress on the floor. A review of R30's Care Plan initiated 03/27/19 for Behaviors instructed staff to monitor his behaviors and attempt to determine a cause with consideration to the location, time of day, persons involved, and situation (03/27/19). The plan instructed to offer R30 smoke breaks, to go outside, and call his daughter when agitated (07/13/21). The care plan instructed that staff should notify hospice if unable to manage his behaviors (08/19/22). A video, provided anonymously to the State Agency (SA), taken on 01/21/23 at 07:02 PM revealed R30 sat on the floor in the hallway outside his room. R30 sat on his knees on a bedsheet without pants signaling to someone in the hallway. R30's Broda chair was not visible in the video. The video recorded R30 spoke to someone outside of the camera range. The video showed R30's room, his bed was visible in a lowered position, with no mattress on the floor. A video provided to the SA anonymously, revealed on 02/10/23 at 07:04 PM R30 was with staff in his room. CMA R and CNA N stood over R30 as he lay partially on the end of a mattress on the floor. The video revealed CMA R held R30's right arm, gestured to CNA N, who then grabbed R30's left arm. Both staff then pulled R30's arms upwards in a hyperextended position (extend a limb or joint beyond its normal limits) as they pulled him back towards the wall on his floor mattress. Staff placed a blanket over him. The video showed R30 attempted to get up from the mattress on the floor as staff turned out the light, exited his room, shut the door and walked away. The video showed R30's call light was under his bed, towards the end of the bed and out of R30's immediate reach from his position on the mattress on the floor. The facility Investigation signed on 02/16/23 and submitted to the State Agency documented that based on the facts discovered in the investigation, the video, and CMA R's statement, it was reasonable to conclude neglect occurred. On 02/13/2023 at 11:40 AM, R30 slept in his bed. The fall mattress was placed next to his bed on the floor. R30's call light sat at the foot of his bed out of reach. R30's room smelled strongly of urine. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/15/23 at 09:43 AM, R30 sat in his Broda chair as the main nurse's station. R30 was using his hands to push his chair away from the wall and moaning. At 09:44AM Administrative Nurse F asked, What's wrong? R30 responded he wanted to go to bed. She stated Okay, I"ll tell them and walked away. R30 remained at the nurse's station moaning but as staff walked by staff failed to stop and intervene. At 09:50AM R30 informed staff he had to pee. Staff responded with C'mon, let's go. At 09:52AM staff wheeled R30 into his room. On 02/16/2023 at 12:46 PM R30 sat in his Broda chair in the main dining room. R30's meal was served on a hard plastic plate and coffee cup. He consumed the majority of his meal. R30 watched television with no behaviors displayed. On 02/13/23 at 08:30 AM, a cognitively intact resident reported he had witnessed, on multiple occasions, staff dragging R30 down the hall and back into him room by his arms. He stated the last time they put R30 on his fall mattress staff let go of his arms and he bounced on the mat. On 02/15/23 at 03:21 PM, Consultant Staff II reported hospice was not contacted about R30's behaviors on 02/10/23. She stated the facility was responsible for updating hospice for changes in R30's behavior or cares. On 02/16/23 at 03:21 PM, CNA N reported R30 often would have to be brought back to his bed due to him leaving his room. She stated that she would usually have to grab his arm or a leg to carry him back to his bed. She stated he required multiple staff to assist with getting back to his room due to his behaviors. She reported staff had to place him on his floor mattress because he would repeatedly get out of bed. On 02/16/23 at 03:51 PM, CMA R stated during the incident on 02/10/23 he was asked to assist moving R30 back to his bed from the hallway. He stated staff found R30 crawling on the floor outside his room and staff needed assistance putting R30 back in his bed. He stated staff often had to drag R30 back into his room. He stated staff left R30 on his floor mattress due to him getting out of bed, crawling out, or falling out of bed. On 02/16/23 at 04:34 PM Administrative Staff B reviewed the video from 02/10/23 and acknowledged staff should not have pulled R30 in the manner that occurred on the video. She stated she was not aware of the incident. She stated that she was aware R30 had behaviors over the weekend but not that aware staff drug him to his room. She reported the resident's representative reported to the facility that R30 preferred sleeping on the floor. A review of the facility's Abuse, Neglect, and Misappropriation policy revised 10/2022 indicated the facility will identify all residents at risk for abuse and implement a plan of care to address the vulnerabilities identified. The policy noted that the facility will ensure all staff have received education and monitoring for signs of abuse. The policy indicated staff will intervene when abuse is observed or reported to protect the resident. The policy noted the facility will ensure the proper training and education for all staff to identify, intervene, report, and protect residents from abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure R30 remained free from staff to resident abuse, neglect and mistreatment when CMA R and CNA N each grabbed R30 by his hands, with his arms extended, and drug him to position him on a mattress, which was on the floor next to R30's bed placed on the floor. CNA N placed a sheet over the resident, and both staff exited the room, turned the light out and shut the resident's door despite the resident being awake and active, on the mattress on the floor. This placed R30 in IJ. On 02/16/23 the facility initiated the following corrective actions to address the immediacy: Both staff involved in the incident were placed on suspension pending the outcome of the investigation. R30 was assessed, hospice and physician notified and orders for x-rays of both arms for R30 were obtained. The event was reported to the State Agency. Staff education was initiated regarding abuse, neglect and exploitation ad well as dealing with resident behaviors and would continue until all staff received the education. No staff were allowed on duty until they received the education. Education was provided to relevant staff regarding R30's condition, behaviors, and techniques to maintain R30's safety, feelings of dignity and overall wellbeing. The facility developed a specific, customized plan for staff to use when providing cares to R30. After removal of the IJ, the scope and severity remained at a G to reflect actual harm based on the reasonable person concept applied due to R30's inability to express the impact of the deficient practice on his physical and psychosocial wellbeing.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility reported a census of 48 residents which included 16 residents sampled for review. Based on observation, interview, and record review, the facility failed to complete the Care Area Assessment (CAA analysis of findings), related to a Comprehensive Minimum Data Set (MDS), for Resident (R)42, and R44, to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. This deficient practice placed these residents Findings included: - R42's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dysphagia (swallowing difficulty. The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented that R42 required extensive assistance of one staff member for activities of daily living (ADLs). The Care Area Assessment (CAA), dated 12/15/22, documentation revealed the following triggered CAAs lacked analysis of findings, as required: 1. Behavioral Symptoms 2. Cognitive Loss/Dementia 3. Activities 4. Psychosocial Well-Being 5. Communication On 02/16/23 at 09:53 AM Administrative Nurse F stated she was not aware that R42's CAAs were not completed. Administrative nurse F stated she had only been employed about six weeks. Administrative nurse F stated the CAA's are what help formulate each resident's care plan. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Assessment Instrument, (R.A.I.) Manual, Section 2.7 titled The Care Area Assessment (CAA) Process and Care Plan Completion, dated 2019, documentation included . Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based Trigger conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process. CAA(s) completion is required for comprehensive assessments. The facility failed to complete the CAAs related to a Comprehensive Minimum Data Set (MDS), for R42, as required, to address the underlying cause, risk factors, and other contributing factors to ensure R42 received care based on their individual needs. - R44's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), dementia (progressive mental disorder characterized by failing memory, confusion), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented that R44 required extensive assistance of one staff member for activities of daily living (ADL's). The Care Area Assessment (CAA), dated 12/15/22, documentation revealed the following triggered CAAs lacked analysis of findings, as required: 1. Behavioral Symptoms 2. Cognitive Loss/Dementia 3. Delirium 4. Communication On 02/16/23 at 09:53 AM Administrative Nurse F stated she was not aware that R44's CAAs had not been completed. Administrative nurse F stated she had only been employed about six weeks. Administrative nurse F stated the CAA's are what help formulate each resident's care plan. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Assessment Instrument, (R.A.I.) Manual, Section 2.7 titled The Care Area Assessment (CAA) Process and Care Plan Completion, dated 2019, documentation included . Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based Trigger conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process. CAA(s) completion is required for comprehensive assessments. The facility failed to complete the CAAs related to a Comprehensive Minimum Data Set (MDS), for R44, as required, to address the underlying cause, risk factors, and other contributing factors to ensure R44 received care based on their individual needs.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, record review, and interviews, the facility failed to identify a significant change in the physical condition and complete a comprehensive Significant Change Minimum Data Set (MDS) for Resident (R) 19. This deficient practice placed R19 at risk of alteration in care needed to maintain highest functional status. Findings included: - R19's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition, and no staff interview was completed. The MDS documented R19 required limited assistance of one staff member for activities of daily living (ADL). The MDS documented no weight loss during look back period. The Quarterly MDS dated [DATE] documented severely impaired cognition. The MDS documented R19 required extensive assistance of one staff member for ADL. The MDS documented R19 had weight loss during the look back period, but not a physician ordered weight loss. On 01/04/23 at 01:19 PM a Nutrition Progress Note documented a Registered Dietician review for quarterly/significant weight loss. The note recorded R19's current weight was 141.5 pounds on 01/02/23, which reflected a 11 pound and (7.2%) weight loss in one month. Review of R19's clinical record documented a decline is R19's functional status as he went from requiring limited assistance to requiring extensive assistance, as documented on the Quarterly MDS dated [DATE]. On 02/15/23 at 10:55 AM R19's breakfast tray with lid sat on the bedside table. The breakfast tray had two small cups of juice, and no chocolate milk or health shake was noted on the tray. R19 laid on the bed with eyes closed. On 02/16/23 at 09:53 AM Administrative Nurse F stated the interdisciplinary team (IDT) met daily and reviewed the documentation for the past 24 hours during the week and 72-hour report on Mondays. The IDT review weight loss and any other changes. Administrative Nurse F stated she did not know of R19's weight loss and decline in ADL. Administrative Nurse F stated that would possibly indicate a need for a Significant Change MDS. The facility's MDS Completion and Submission Timeframes policy last revised July 2017 documented the timeframes for Completion and submission of assessments are based on the current requirements published in the Resident Assessment Instrument Manual. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to identify a significant change in R19's physical condition, and complete a comprehensive Significant Change MDS, placing the resident at risk for not receiving needed cares.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 38 had a baseline care plan to address her dementia (a progressive mental disorder characterized by failing memory, confusion) care, mental health conditions and behaviors. This deficient practiced places R38 at risk for unmet care needs for a resident with dementia. Findings included: - The electronic medical record (EMR) for R38 documented diagnoses of: senile degeneration of the brain (memory loss, difficulty concentrating, finding it hard to carry out familiar daily task, struggling to follow a conversation or find the right word, being confused about time and place, and mood changes), neurocognitive disorder (dementia), pseudobulbar affect (a condition that's characterized by episodes of sudden uncontrollable and inappropriate laughing or crying). The Admission Minimum Data Set (MDS) dated [DATE] documented R38 had both long and short-term memory problem. R38 had moderately impaired cognitive skills for daily decision-making skills. R38 showed signs and symptoms of delirium (sudden severe confusion, disorientation and restlessness) with inattention that was present and fluctuated. R38 displayed daily behaviors that significantly interfered with residents in activities or social interaction. R38 significantly intruded on the privacy of others and wandered daily. The Activities of Daily Living (ADL) Care Area assessment dated [DATE] documented R38 required supervision for ADL except for bathing, which required total assistance. R38 required supervision due to severe cognitive impairment and lack of safety awareness. R38 was on hospice services and a decline in self-care ability was anticipated. The Baseline Care Plan initiated 01/24/23 did not have a care area specific to dementia care. The Behavior Care Plan initiated 01/21/23 directed staff to minimize potential for the resident's disruptive behaviors by offering tasks which divert attention. Staff were to provide a program of activities that was of interest and accommodated the resident's status. On 02/14/23 at 11:35 AM R38 walked about the dementia unit and wandered into a male resident's room. On 02/14/23 at 01:39 PM R38 walked about the dementia unit and walked into another female residents' room and that resident told R38 to get out of her room. On 02/16/23 at 12:41 PM Licensed Nurse (LN) H stated the baseline care plan auto generates from the initial assessment and was usually completed by the MDS coordinator. LN H stated she expected someone with dementia to have a care plan to address the specific cares needed to care for a resident with dementia. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 01:45 PM Administrative Nurse E stated on admission, the MDS coordinator took information from the initial assessment information and the baseline care plan was autogenerated from that information. Administrative Nurse E stated she expected a resident with dementia to have a care plan specific to dementia. The Dementia- Clinical Protocol policy revised 11/2018 documented: for the individual with confirmed dementia, the Interdisciplinary Team (IDT) would identify a resident-centered care plan to maximize remaining function and quality of life. The facility failed to ensure a person-centered baseline care plan to direct staff to care for a resident with dementia, R38. This placed R38 at risk for unmet care needs being met and further decline.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified as census of 48 residents. The sample included 16 residents. Based on record review and interview, the facility failed to ensure Resident (R) 50's discharge summary included a recapitulation of stay and medication reconciliation. This placed R50 at risk for not receiving timely and appropriate care. Findings included: - The Electronic Medical Record (EMR) for R50 identified diagnoses of cognitive communication deficit (difficulty with thinking and how someone uses language), dysphagia (difficulty swallowing), muscle weakness, and vision loss. The Admission Minimum Data Set (MDS) dated [DATE] documented R50 had a Brief Interview for Mental Status of (BIMS) score of 11, which indicated moderately impaired cognition. R50 was independent with Activities of Daily Living (ADL) and required supervision with locomotion on the unit. R50 had no history of falls prior to admission. The Discharge MDS dated [DATE] documented a planned discharge to another nursing facility. R50's Discharge Care Plan dated 12/15/21 documented R50 planned to stay at the facility for long term care and did not plan to discharge. The Notification of Facility Admission/Discharge documented a discharge date of [DATE] to another nursing facility. R50's clinical record lacked evidence of a recapitulation of R50's stay or a reconciliation of his medications. The facility was unable to provide upon request. On 02/16/23 at 12:55 PM Licensed Nurse (LN) G stated when a resident had a planned discharge to another facility the face sheet, list of medications, the diagnoses are included in the packet sent with the resident. LN G stated he was not certain the facility did a recapitulation of stay. LN G stated the receiving facility would get called and be given report on the resident's current status. On 02/16/23 at 01:45 PM Administrative Nurse E stated a discharge summary was completed that included the diagnoses, the list of medications and that kind of stuff was sent in a packet to the facility, but a recapitulation of stay was not done or the reconciliation of the medications. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Discharge Summary policy last revised 11/08/22 documented: the discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plan for care after discharge. The discharge summary must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. For residents being discharged to another health care facility, the discharge summary enables the receiving facility to provide appropriate and timely care. Recapitulation of the resident's stay describes the resident's course of treatment while residing in the facility. The recapitulation included but was not limited to, diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results. The facility failed to ensure R50's discharge summary included a recapitulation of stay and medication reconciliation. This placed R50 at risk for not receiving timely and appropriate care.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 48 residents. The sample included 16 residents with six residents reviewed for Activities of Daily Living (ADL). Based on observation, record review, and interviews, the facility failed to ensure staff used a gait belt when walking with Resident (R) 25 who required limited assistance (resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance) of one staff member for ambulation. This deficient practice placed R25 at risk of loss of functional abilities. Findings included: - R25's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of muscle spasm, dementia (progressive mental disorder characterized by failing memory, confusion), and traumatic brain injury (usually results from a violent blow or jolt to the head or body) and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R25 required limited assistance of one staff member for ADL. R25's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/12/23 documented R25's cognitive impairment was related to R25's diagnosis of dementia. R25's Care Plan dated 08/26/21 documented R25 ambulated with a walker and stand-by assistance. On 02/14/23 at 07:45 AM R25 ambulated with a front wheeled walker from their room to the dining room with a Certified Nurse Aide (CNA) O without a gait belt in use. On 02/15/23 at 09:16 AM R25 ambulated with a front wheeled walker from the dining room while Licensed Nurse (LN) G held onto R25's belt loop. LN G did not use a gait belt. On 02/16/23 at 09:23 AM Consultant HH stated a gait belt should always be used when staff walk beside a resident. Consultant HH stated when a resident was coded as a stand-by assistance, the staff should use a gait belt if the resident would allow it. Consultant HH stated there were extra gait belts available in the therapy room. On 02/16/23 at 12:50 PM Certified Nurse Aide (CNA) M stated staff should always use a belt when they walked with a resident for safety to help prevent falls which could result in an injury. On 02/16/23 at 01:03 PM Licensed Nurse (LN) H stated staff should always use a gait belt for stand-by assistance of a resident. LN H stated gait belts help prevent falls and injuries. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 01:50 PM Administrative Nurse E stated all nursing staff have gait belts and the expectation was that they use them on every resident that needed assistance with any ADL. Administrative Nurse E stated she had not seen any staff using a gait belt in the past several days. The facility's Aspects of Daily nursing Care policy last reviewed 11/16/22 documented the residents would be provided with care, treatment, and services to assist the resident in attaining and maintaining the maximum physical and psychosocial well-being to ensure quality of life. The facility failed to ensure staff used a gait belt when ambulating with R25. This deficient practice placed R25 at risk of not maintaining his highest physical and psychosocial well-being to ensure his quality of life.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. 45668 The facility identified a census of 48 residents. The sample include 16 residents with five residents reviewed for activities. Based on observation, record review, and interviews, the facility failed provide ongoing activities for the facility during weekends. This deficient practice placed 48 residents at risk for decreased psychosocial well-being. Findings included: - A review of the facility's Activity Calendar for December 2022, January and February of 2023 revealed the majority of the weekend days were left blank with no activities indicated and/or scheduled. On 02/13/23 at 09:00 AM Administrative Staff stated the facility's previous certified Activities Coordinator (AC) resigned in December 2022. She reported the facility was currently looking for a new AC. On 02/14/23 at 03:38 PM, Resident Council members reported that the facility has struggled with activities on weekends due to the recent loss of the AC in December. One alert and cognitively intact resident stated that the weekend managers will hold the groups sometimes on weekends but some days they do not. The resident stated that when the previous activities coordinator resigned the place kind of a fell apart. On 02/16/23 at 01:25 PM Licensed Nurse (LN) H reported that on weekends a Certified Nurse Aide (CNA) or the on duty manager would be responsible for completing the activities. On 02/16/23 at 12:45 PM Social Services X reported that the facility has been without an AC since the beginning of December 2023. He stated the Administrative Staff B was responsible for creating the activities schedule, but some staff and the weekend managers were responsible for completing the scheduled groups. He stated that the groups should be on the weekends as well. A review of the facility's Activities Program policy revised 06/2018 indicated activities were provided to meet the interest and support the well-being of the residents. The facility failed provide ongoing activities for the facility during weekends. This deficient practice placed 48 residents at risk for decreased psychosocial well-being.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure staff monitored and provided treatment and care for Resident (R) 4's bowel management. The facility further failed to involve and notify hospice to provide adequate end of life care for R30. This deficient practice placed R4 at risk for constipation and R30 at risk for inadequate care and unmet psychosocial needs. Findings included: - The Electronic Medical Record (EMR) for R4 documented diagnoses of hemiplegia and hemiparesis following a stroke (paralysis and weakness of one side of the body). The Annual Minimum Data Set (MDS) dated [DATE] documented R4 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R4 required limited assistance of one staff member with toileting. R4 was always continent of bowel. The Urinary/Incontinence Care Area assessment dated [DATE] documented R4 was frequently incontinent of bladder but was continent of bowel. The ADL Care Plan revised 12/26/22 directed staff the resident needs limited assistance of one staff member for toilet use. The February Order Summary documented an order dated 01/17/21 if no bowel movement for three days, give 120 milliliters (ml) of prune juice as needed for constipation. If prune juice was not effective in 24 hours, progress to day four orders. The February Order Summary documented an order dated 06/02/22 for bisacodyl (a type of medicine to help empty the bowel) EC tablet delayed release five milligram (mg), give two tablets by mouth every 24 hours as needed for constipation. Take 10mg daily as needed. The November 2022 Documentation Survey Report documented R4 had no documented bowel movement for 13 out of 30 days, as follows: 11/01/22, 11/02/22, 11/03/22, 11/04/22, 11/05/22, 11/07/22, 11/08/22, 11/09/22, 11/10/22, 11/11/22, 11/12/22, 11/13/22. The Treatment Administration Record (TAR) for November 2022 lacked evidence the staff administered R4's as needed prune juice or bisacodyl. The Progress Notes reviewed for the month of November showed no documentation related to an as needed laxative (a medication used to treat constipation) administered to address R4's lack of bowel movement for more than three days. On 02/15/23 at 08:44 AM R4 sat in his wheelchair at the dining table eating breakfast. On 02/15/23 at 01:38 PM R4 sat in his wheelchair in his room and stated he knew when he needed to have a bowel movement and usually had one daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 12:43 PM Certified Nurse Aide (CNA) O stated the aides documented when a resident had a bowel movement or if a resident told them they had had one. CNA O said the nurse was alerted in the EMR when a resident had gone a couple of days without a bowel movement. On 02/16/23 at 12:49 PM Licensed Nurse (LN) H stated the nurse was alerted on the clinical dashboard if a resident had gone 48 hours without a bowel movement and then again at 72 hours. LN H stated a progress note should be generated that the resident had gone three days without a bowel movement and the nurse would tell the medication aide that the resident needed to be given an as needed laxative, that should be charted on the TAR. LN H stated R4 was continent of bowel and might not always tell the aide that he had a bowel movement. On 02/16/23 at 01:45 PM Administrative Nurse E stated the EMR automatically flagged a resident that had not had a documented bowel movement after 48 hours and then again after 72 hours. The nurse should inform the medication aide that the resident needed to be given an as needed laxative. Administrative Nurse E stated she would expect there to be documentation that the resident had not have a bowel movement in three days and the as needed medication had been given. The Bowel Disorders - Clinical Protocol policy revised 09/2017 documented: staff and physician would monitor the individual's response to interventions and overall progress, overall degree of comfort or distress, frequency and consistency of bowel movements and the frequency, severity, and duration of abdominal pain. The facility failed to ensure staff monitored and provided physician ordered treatment/interventions as needed for R4 who went more than three days without a documented bowel movement. 45668 - The Medical Diagnosis section within R30's Electronic Medical Records (EMR) included diagnoses of alcohol induced dementia (progressive mental disorder characterized by failing memory, confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), muscle weakness, lack of coordination, restlessness, and agitation. R30's Significant Change Minimum Data Set (MDS) completed 12/08/22 noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated R30 had verbal behaviors directed towards others and himself. The MDS noted his behaviors significantly interfered with his care. The MDS noted that he had a history of rejecting care. The MDS noted he required extensive assistance from two staff for bed mobility, transfers, dressing, personal hygiene, toileting, and bathing. The MDS noted he required a wheelchair for mobility. The MDS indicated that he was receiving hospice services. A review of R30's Cognitive Loss/Dementia Care Area Assessment (CAA) completed 12/08/22 indicated R30 had a diagnosis of dementia. The CAA noted he had a decreased ability to make himself understood, decline in continence, and needed assistance with his Activities of Daily Living (ADL). A review of R30's Communication CAA completed 12/08/22 indicated he had impairments related to expression, reception of information, difficulty pronouncing and describing, and had difficulty putting sentences together. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R30's Behavior CAA completed 12/08/22 indicated he had a history of rejection of care and verbal behaviors towards others. A review of R30's Care Plan initiated 09/09/19 for Cognitive Function indicated that R30 had impaired cognitive function related to his medical diagnoses and impaired thought process. The plan noted he was at risk for abuse and instructed staff to approach him in a calm manner, address him by his name, and provide him personal space (11/05/20). The plan indicated he should be provided a home-like environment (07/19/21). A review of R30's Care Plan initiated 08/15/22 for Advanced Directives indicated that R30 was receiving hospice services. The plan indicated hospice would supply durable medical equipment, medications related to his diagnosis, skin treatments, incontinence supplies, and other treatment/supplies related to his comfort. The care plan instructed that staff should notify hospice if unable to manage his behaviors (08/19/22). A review of R30's Care plan initiated 03/27/19 for Behaviors instructed staff to monitor his behaviors and attempt to determine a cause with consideration to the location, time of day, persons involved, and situation (03/27/19). The plan instructed staff to offer smoke breaks, go outside, and call his daughter when agitated (07/13/21). A review of R20's EMR under Progress Note on 01/22/23 at 04:20 PM indicated that R20 was in the dining room and made several attempts to jump out of his Broda chair. The note indicated that staff placed him on his floor mattress and left him in his room. The note indicated that R20 then crawled out into the hallway crying for help. The note lacked notification to hospice or intervention attempted to address his crawling. A review of R20's Progress Note on 01/22/23 at 12:17 AM indicated that R20 had periods of extreme agitation, fighting with staff members, and repeated climbing out of his Broda chair to the floor. The note indicated he acquired multiple skin tears due to his behaviors. The note indicated that he received Haldol per medical providers orders. The note lacked documentation hospice was notified A review of R20's Progress Note for 01/29/23 indicated he had extreme agitation but lacked documentation showing hospice was notified. The note lacked documentation of interventions provided by staff or staff effort to assess and/or evaluate R30's needs. A review of R20's Progress Note for 01/31/23 indicated he had extreme agitation but lacked documentation showing hospice was notified. The note lacked documentation of interventions provided by staff or staff effort to assess and/or evaluate R30's needs. A review of R20's Progress Note for 02/08/23 indicated he had extreme agitation but lacked documentation showing hospice was notified. The note lacked documentation of interventions provided by staff or staff effort to assess and/or evaluate R30's needs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A video provided to the SA anonymously, revealed on 02/10/23 at 07:04 PM R30 with staff in his room. Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) N stood over R30 as he lay partially on the end of a mattress on the floor. The video revealed CMA R held R30's right arm, gestured to CNA N who then grabbed R30's left arm. Both staff then pulled R30's arms upwards in a hyperextended position (extend a limb or joint beyond its normal limits) as they pulled him back towards the wall on his floor mattress. Staff placed a blanket over him. The video showed R30 attempted to get up from the mattress on the floor as staff turned out the light, exited his room, shut the door, and walked away. The video showed R30's call light was under his bed, towards the end of the bed and out of R30's immediate reach from his position on the mattress on the floor. R30's clinical record lacked evidence the facility notified hospice regarding R30's behaviors in an effort to obtain assistance with oversight, pain management, and evaluation of the resident's comfort and needs. On 02/15/23 at 10:04 AM, CNA P stated the facility staff struggled to address R30's behaviors and often overlooked them. She stated the last time she was in the facility she asked for assistance with R30's behaviors and staff would tell her that's just him and would not help. She stated she even asked Social Services X for assistance and was told that's just [R30]. She stated that when she cared for R30 she would frequently offer him snacks, escort around the facility, give him smoke breaks, and spend time with him to keep him calm. She stated that the facility often would not take the time with him and by the time she comes to care for him, he would already be agitated. She stated the facility would just hand him over upset and expect hospice to calm him down. She stated that she would activate his call light and staff would not respond to assist during his behavioral episodes. On 02/15/23 at 03:21 PM, Social Service Y reported that hospice was not contacted about R30's behaviors on 02/10/23. She stated that the facility was responsible for updating hospice for changes in R30's behavior or cares. She stated that the hospice would adapt to R30's needs to find out what was causing his behaviors. On 02/16/23 at 03:21 PM, CNA N reported R30 often would have to be brought back to his bed due to him attempting to leave his room. She stated she would usually have to grab his arm or a leg to carry him back to his bed. She stated he required multiple staff to assist with getting back to his room due to his behaviors. She reported that staff had to place him on his floor mattress because he would repeatedly get out of bed. She reported that he had repeated behaviors of crawling out of bed and was not sure what he needed. On 02/16/23 at 03:51 PM, CMA R stated that during the incident on 02/10/23 he was asked to assist moving R30 back to his bed from the hallway. He stated that staff found R30 crawling on the floor outside his room and needed assistance putting him back in his bed. He stated that staff often have to drag in back into his room. CMA R stated that he was passing medication in another hall and staff called for assistance. He stated that staff left R30 on his floor mattress due to him getting out of bed, crawling out, or falling out of bed. On 02/16/23 at 04:00 PM, Licensed Nurse (LN) H stated that hospice should be notified for all changes in condition, falls, behaviors, injuries, pain, and other relevant care concerns. She stated that the hospice book and phone number were kept at the main nurse's station. She stated that both nurses and direct care staff are made aware of that before starting. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 04:34 PM Administrative Nurse E stated that hospice should be notified with all behavioral episodes and changes in condition for the residents. She stated the facility usually contacts hospice services for every incident for R20. She was not sure why they were unaware. She stated that the hospice books were kept at the nurse station. On 02/17/23 Administrative Nurse E stated that hospice was called on 02/16/23 and notified of the alleged abuse concerning R30. A review of the facility's Hospice policy revised 07/2017 indicated that it was the facility responsibility to notify hospice of any mistreatment of the resident including abuse, neglect, or misappropriation. The policy also noted that the facility will provide communication and documentation to ensure the resident's needs are met 24 hours a day. The facility failed to notify and involve hospice regarding R30's behavioral needs and potential other physical or emotional needs. This deficient practice place R30 at risk for inadequate end of life cares and unmet physical and psychosocial needs.

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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. 45668 The facility identified a census of 48 residents. The sample include 16 residents with one resident reviewed for pressure ulcer/injuries (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 identify, consistently assess, and document Resident (R)20's lower left leg wound. This deficient practice placed R20 at risk for impaired healing and infections. Findings included: - The Medical Diagnosis section within R20's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), heart failure, dyspnea (difficulty breathing), chronic obstructive pulmonary disorder (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), morbid obesity (severely overweight), and fracture (broken bone) of the right tibia (bone of the lower leg), and fracture of both right and left femur (thigh bone). R20's Quarterly Change Minimum Data Set (MDS) completed 01/25/23 noted a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS indicated he required extensive assistance from two staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated R20 had a stage two pressure injury (superficial wound with exposed wound bed under the top layer of the skin). A review of R20's Activities of Daily Living (ADL) Care Area Assessment (CAA) completed 09/29/22 indicated he required extensive to dependent assistance with his ADL from two or more staff for his positioning needs. The CAA noted he had a history of multiple fractures (broken bones) and remained non-weight bearing. A review of R20's Pressure Ulcer CAA completed 09/29/22 indicated he was at risk for skin breakdown and pressure injuries related to impaired bed mobility, morbid obesity, and bowel/bladder incontinence. The CAA instructed staff to monitor for signs of infection. The CAA instructed staff to turn and reposition frequently, keep him clean and dry, use a pressure reducing mattress, and encourage good nutrition. A review of R20's Fall CAA completed 09/29/22 indicated that R20 had a fall on 09/01/22 resulting multiple severe fractures to both legs. The CAA indicated that he was non-weight bearing and decreased mobility due to healing. A review of R20's Care Plan initiated 07/21/22 for ADLs indicated R20 required total assistance from one to two staff for bed mobility. The plan noted staff may use a draw sheet when moving up in the bed to prevent sheering. The plan indicated he required assistance from two staff member for repositioning. The plan also indicated staff may use a Hoyer (full body lift) lift as needed for transfers (08/12/22). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R20's Care Plan initiated 04/18/22 for Skin Prevention Care indicated R20 was at risk for skin breakdown and development of pressure injuries related to his diagnoses and mobility issues. The plan instructed R20 to use a pressure relieving mattress, identify risk/causative factors, monitor/document skin injuries, and treat skin injuries as needed. A review of R20's EMR under Skin Observation revealed a note 10/10/22 indicating that R20 had an existing skin impairment noted as a vascular wound on his left lower leg. The note lacked documentation of the wound bed characteristic or measurements or presence of infection. The note lacked documentation showing the physician was notified. A Skin Observation note completed on 10/17/22 indicated that the left lower leg wound was assessed as a pressure injury. The note lacked documentation of the wound bed characteristic or measurements or presence of infection. The note lacked documentation showing the physician was notified. The EMR had no documentation of this wound between 10/17/22 to 11/04/22. A Non-Pressure Progress Note completed on 11/04/22 indicated that R20's wound was documented as a non-pressure injury. The note indicated that R20 admitted with the full thickness wound with epithelial tissue present covering 50 percent of the wound bed. The note lacked documentation showing the physician was notified. The EMR indicated R20 began seeing the consultant wound care providers (WCP) on 11/04/22. A Wound Care Note completed 11/04/22 classified R20's lower left leg wound as an undiagnosed anterior (front) wound measuring 4.5 centimeters (cm) in length by 3.0cm wide by 0.1cm in depth (4.5cm x 3.0cm x0. 1cm) with an overall area of 13.5 square centimeters (cm/sq.). The note revealed the wound was debrided, cleaned, and dressed during the assessment. The note recommended a weekly follow-up. A Wound Care Note completed 11/11/22 noted R20's lower left leg wound measured 2.5cm x 2.9cm x 0.1cm with an overall area of 7.25 cm/sq. The note labeled the wound as a full thickness non-pressure injury. The note revealed the wound was assessed, cleaned, and dressed during the assessment. The note recommended a weekly follow-up. A Wound Care Note completed 11/18/22 noted R20's lower left leg wound measured 2.6cm x 2.8cm x 0.1cm with an overall area of 7.28 cm/sq. The note revealed the wound was assessed, cleaned, and dressed during the assessment. The note recommended a weekly follow-up. A Wound Care Note completed 11/25/22 noted R20's lower left leg wound measured 1.5cm x 1.5cm x 0.1cm with an overall area of 2.25 cm/sq. The note revealed the wound was assessed, cleaned, and dressed during the assessment. The note recommended a weekly follow-up. A Wound Care Note completed 12/02/22 noted R20's lower left leg wound was healed. A Skin Observation note completed on 12/10/22 indicated R20 lower left leg wound was labeled as vascular. The note lacked measurements or documentation of the wound bed characteristic. The note lacked documentation showing the physician was notified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin Observation note completed on 12/17/22 indicated R20 lower left leg wound was labeled as surgical. The wound measured 2.8cm x 3.0cm x 0cm. The note lacked documentation of the wound bed characteristic. The note lacked documentation showing the physician was notified. The EMR had no documentation of this wound from 12/17/22 through 01/14/23. On 01/14/23 R20's lower left extremity wound was identified as a stage two pressure injury on the Weekly Wound Rounds chart. The note indicated the wound measured 2.8cm x 3.0cm x 0.1cm. The note indicated treatment for it was to apply triple antibiotic ointment, cover the wound, and dress it. On 01/21/23 the Weekly Wound Rounds chart indicated R20's lower left leg pressure injury measured 0.4cm x 1.0cm x 0cm. The note indicated treatment for it was to apply triple antibiotic ointment, cover the wound, and dress it. On 01/25/23 the Weekly Wound Rounds chart indicated R20's wound had healed. On 02/13/23 at 10:26 AM R20 watched television from his bed. R20's bed was a pressure reduction mattress. R20 reported that his lower left leg occurred before his admission to the facility when his tractor overturned on his and caught fire. The wound outline was visible but healed over on the center of the front of his left lower leg. He reported that he had continued issues with it reopening. On 02/16/23 at 01:25 PM Licensed Nurse (LN) H reported that she for wound the nurses would complete assessment and reporting to the physician. She stated that she was told the nurses could not measure the wound. She stated that only WCP was supposed to measure the wounds. She stated that R20's wound began as a vascular wound and was treated by WCP until his wound started healing. She stated he was discharged from WCP. She stated that the nurses should be completing weekly skin assessment and noting down their findings. On 02/12/23 at 03:35 PM Administrative Nurse reported that initially R20's wound was thought to be an old scar. She stated that during a mock survey the facility started treating it as a vascular wound. She stated that she and her Regional Nurse assessed and believed it to be a pressure injury while WCP noted it as an undiagnosed non-pressure injury. She stated nurses should complete weekly skin and wound assessments. She stated staff nurses should be measuring and documenting the wounds regardless if WCP treated the resident. A review of the facility's Skin Wound policy revised 11/2022 indicated the facility will ensure each resident receives care to prevent, heal, and minimize the risk of skin/pressure injury development unless the individual's clinical condition demonstrates it unavoidable. The facility failed to identify, consistently assess, and document R20's lower left leg wound. This deficient practice placed R20 at risk for impaired healing and infections.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 39 who had a contracture (an abnormal permanent fixation of a joint) received appropriate restorative treatments to help maintain mobility. This deficient practice placed R39 at risk for a decline in range of motion and decreased mobility. Findings included: - The Electronic Medical Record (EMR) for R39 documented diagnosis of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk). The Annual Minimum Data Set (MDS) dated [DATE] documented R39 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R39 required extensive assistance of one to two staff for Activities of Daily Living (ADL). R39 had functional impairment of both upper and lower extremities on both sides. R39 required the use of a wheelchair for mobility. R39 did not receive any restorative programs. The Quarterly MDS dated [DATE] documented R39 had a BIMS score of one, which indicated severely impaired cognition. R39 required extensive assistance of one to two staff for ADL. R39 had functional impairment of both upper and lower extremities on both sides. R39 required the use of a wheelchair for mobility. R39 received both active and passive restorative programs. The Restorative Care Plan for R39 was resolved on 08/17/22. The Documentation Survey Report for R39 documented tasks for active and passive restorative program to be done to bilateral upper and lower extremities at least three times weekly. Review of the Documentation Survey Report for January 2023 revealed that R39 did not consistently receiving restorative treatments to maintain mobility and range of motion on eight of 24 opportunities. The February 2023 Documentation Survey Report revealed R39 received restorative on 02/02/23, 02/07/23 and 02/15/23. On 02/14/23 at 01:08 PM R39 sat in his high-back wheelchair at the dining table feeding himself with his right hand, his left arm was contracted in a position close to his chest. On 02/15/23 at 08:43 R39 sat in his high-back wheelchair at the dining table trying to reach the glass of orange juice with his right hand, a staff member came to assist R39 to move the glass so the resident could reach it. On 02/16/23 at 12:55 PM Licensed Nurse (LN) G stated the facility was not providing restorative services at this time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 01:45 PM Administrative Nurse E stated she just found out the facility currently stopped doing restorative. Administrative Nurse E stated R39 should be receiving restorative services due to his contractures. The Restorative Nursing Services policy revised 7/2017 documented: residents would receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals may include but are not limited to supporting and assisting the resident in maintaining his/her dignity, independence, and self-esteem; and participating in the development and implementation of his/her plan of care. The facility failed to ensure a restorative program was consistently provided to R39 to help maintain mobility. This placed R39 at risk for a decline in range of motion and decreased mobility.

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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** 41713 The facility identified as census of 48 residents. The sample included 16 residents, with nine residents sampled for accidents Based on observation, record review, and interview, the facility failed to ensure the environment remained free from accident hazards and staff provided adequate supervision for Resident (R) 50, who stood up in the unattended dining room and slipped on food and liquids on the floor. The facility further failed to ensure R13's bed was maintained at safe level as directed by his plan of care. These deficient practices placed the residents at risk for accidents and related injuries. Findings included: - The Electronic Medical Record (EMR) for R50 identified diagnoses of cognitive communication deficit (difficulty with thinking and how someone uses language), dysphagia (difficulty swallowing), muscle weakness, and vision loss. The Admission Minimum Data Set (MDS) dated [DATE] documented R50 had a Brief Interview for Mental Status of (BIMS) score of 11, which indicated moderately impaired cognition. R50 was independent with Activities of Daily Living (ADL) and required supervision with locomotion on the unit. R50 had no history of falls prior to admission. The Quarterly MDS dated [DATE] documented R50 had a BIMS score of 11, which indicated moderately impaired cognition. R50 was independent with ADL. R50 had no history of falls during the lookback period. R50's ADL Care Plan initiated 12/10/21 documented R50 was independent with his ADL. R50 ambulated independently and was a low fall risk. The 10/30/22 Witnessed Fall Report dated 10/30/22 at 01:51 PM documented Licensed Nurse (LN) H was called to the dining room by staff and noted R50 was lying on the floor near the table he had just eaten lunch at, and he was holding his shoulder. R50 wrote on his white board that he slipped in the dining room and hit his shoulder. R50 was alert and oriented times four. R50 was assessed and had no obvious injury. Staff was not present in the dining room at the time of the fall. Staff was educated on remaining in the area with spills until spills were addressed. The Interdisciplinary (IDT) Post Fall Review dated 10/30/22 at 01:51 PM documented R50 had a fall that occurred on 10/30/22 at 12:30 PM. R50 complained of pain in his left shoulder. The kitchen staff reported the resident fell in the dining room. The kitchen staff further stated food spilled and the aide went to get the mop to clean it up, and the resident slipped on the food while the aide was gone. R50 complained of pain in his left shoulder. R50 did not hit his head. R50 was at the dining room table and walking. Resident had slippers on at time of incident. Intervention recommended was to educate staff on spills and the need for one staff to wait at the spill for a caution sign before leaving unattended. R50 was educated during mealtimes to watch for spills. The physician and family representative were notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 12:41 PM Certified Nurse Aide (CNA) O stated there should always be someone present in the dining room if residents were still present. CNA O stated she would stay in the dining room until another staff member was present before she would leave to get a mop to clean up a spill, that way the residents would be kept safe from the possibility of slipping. On 02/16/23 at 12:49 PM LN H stated she was called to the dining room by kitchen staff when R50 slipped and fell . LN H stated she assessed R50 after his fall and completed a fall investigation. The IDT goes over the fall the next day and puts the new interventions to be implemented in place. On 02/16/23 at 01:45 PM Administrative Nurse E stated there should always be a staff member present in the dining room and she would expect staff not to leave the residents alone until another staff member was present so one of the staff could go get a mop and a wet floor caution sign to avoid an incident/fall from happening. The Falls policy dated 11/16/22 documented the facility shall provide an environment that was free from accident hazard over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This included: identifying hazards and risks; evaluation and analyzing hazards and risks; implementing interventions to reduce hazards and risks; and monitoring for effectiveness and modifying interventions when necessary. The facility failed to ensure the environment remained free from accident hazards and failed to ensure adequate staff supervision for R50, who stood up in the unattended dining room and slipped on food and liquids spilled on the floor. This deficient practice placed the residents at risk for accidents and related injuries.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 48 residents. The sample included 16 residents with one resident reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to monitor Resident (R) 19's significant weight loss and implement recommendations to prevent further weight loss. This deficient practice placed R19 at risk of malnutrition and other negative outcomes. Findings included: - R19's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition, and no staff interview was completed. The MDS documented R19 required limited assistance of one staff member for Activities of Daily Living (ADL). The MDS documented no weight loss during the look back period. The Quarterly MDS dated [DATE] documented severely impaired cognition. The MDS documented R19 required extensive assistance of one staff member for ADL. The MDS documented R19 had a weight loss during the look back period, but was not on a physician ordered weight loss program. R19's Nutritional Status Care Area Assessment (CAA) dated 06/28/22 documented R19 had a weight gain. R19's Care Plan dated 01/03/23 documented staff would monitor weights as ordered and as needed. Review of the EMR under Orders tab revealed the following physician orders: Milkshake/House shake after meals, four ounces chocolate shake. Staff were to document the amount consumed, dated 04/05/22. Review of the Medication Administration Record (MAR) reviewed from 01/04/23 thru 02/12/23 lacked documentation of the amount consumed for milkshake/house shake 99 times out of 120 opportunities. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/04/23 at 01:19 PM a Nutrition Progress Note documented a Registered Dietician review for quarterly/significant weight loss. The note recorded R19's current weight was 141.5 pounds on 01/02/23, which reflected a 11 pound (7.2 %) weight loss in one month. Nursing were to notify the physician of weight loss. The note documented R19's current diet was regular with regular texture; dietary continued to offer three glasses of chocolate milk with all meals, per R19's preference, as well as four ounces of mighty shake three times a day (chocolate flavor). Intakes at meals varied depending on R19's mood; the charge nurse felt R19 had been sleeping through meals more since the end of September/October. R19 usually only liked cold cereal so unable to offer fortified cereal. R19 was able to feed himself but needed assistance with tray set up/removing lids etc. due to limited use of his right hand. The staff noted no problems with R19's chewing or swallowing. The note recorded the RD recommended adding R19 to weekly weight list, check with physician/pharmacist regarding medications and sleeping through meals, and consider increasing shakes to eight ounces, three times a day. The clinical record lacked evidence of completed weekly weights as recommended in the 01/04/23 Registered Dietition Progress Note and lacked evidence the health shake was increased, as recommeneded. The record lacked evidence or explanation why the recommendations were not implemented. On 02/13/23 at 11:35 AM R19's breakfast tray with lid sat on the bedside table next to the bed, no cups of fluid noted on the tray. R19 laid on the bed with blankets pulled to chest height. On 02/15/23 at 10:55 AM R19's breakfast tray with lid sat on the bedside table. Breakfast tray had two small cups of juice on the tray; no chocolate milk or health shake was noted on the tray. R19 laid on the bed with eyes closed. On 02/15/23 at 01:14 PM R19's lunch tray with a lid sat on the bedside table next to the bed. No fluids were noted on the tray. R19 laid on the bed with eyes open. On 02/16/23 at 12:50 PM Certified Nurses Aide (CNA) M stated the kitchen never added R19's chocolate milk to the meal trays, nursing staff had to ask for the chocolate milk. CNA M stated set-up assistance for meals included unrolling the silverware, placing all items in reach, and eight ounces of fluid would be offered at each meal. On 02/16/23 at 01:03 PM Licensed Nurse (LN) H stated the charge nurse made a list of the weights needed each day. LN H stated the CNAs got the weights and reported them to the charge nurse. LN H stated the registered dietician reviewed all the weights and documented on the weight loss. LN H stated the CNAs provided the chocolate milk for R19. LN H stated the staff should offer residents at least eight ounces of fluid with meals and snacks. On 02/16/23 at 01:50 PM Administrative Nurse E stated residents should receive 360 milliliters (ml) at meals, 120ml of water and 240ml of any fluid of the resident's choice. Administrative Nurse E stated the registered dietician reviewed the weights and made recommendations. Administrative Nurse E stated the dietary manager reviewed the recommendations and updated the diet orders. Administrative Nurse E stated she did not know why R19 was not a weekly weight. The facility's Weight Assessment and Intervention policy last revised September 2008 documented the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to routinely monitor R19's significant weight loss as recommended by the RD and implement RD recommendations to prevent further weight loss. This deficient practice placed R19 at risk of continued unintended weight loss and malnutrition.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 48 residents. The sample included 16 residents, with one resident reviewed for dialysis services. Based on observation, record review, and interview, the facility failed ensure collaberation with the dialysis provider for Resident (R) 32 and failed to ensure dialysis communication sheets were completed/returned with the resident after returning from the dialysis clinic. This left R32 at risk for improper care and treatment needed for a dialysis. Findings included: - The Electronic Medical Record (EMR) for R32 documented diagnoses of end stage renal disease (ESRD, medical condition in which a person's kidneys cease functioning on a permanent basis) and dependence of renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). The Annual Minimum Data Set (MDS) dated [DATE] documented R32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R32 was independent with Activities of Daily Living (ADL) and used a walker or wheelchair for mobility. R32 was occasionally incontinent of urine and received dialysis. The Quarterly MDS dated [DATE] documented R32 had a BIMS of 15, which indicated intact cognition. R32 was independent with his ADL and used a wheelchair for mobility. R32 required dialysis services. The Dehydration/Fluid Maintenance Care Area Assessment (CAA) dated 04/12/22 documented R32 required dialysis for ESRD and was at risk for fluid overload/imbalance. The Dialysis Care Plan revised 01/13/23 documented dialysis communication record was sent to the dialysis center with each appointment and return of the form was ensured after each appointment was completed. The Order Summary Report for February 2023 documented a physician's order for Dialysis on Tuesday, Thursday and Saturday with a chair time of 10:30 AM, staff were to send dialysis communication, and a sack lunch with the resident. Review of R32's Dialysis Book revealed the facility did not have a dialysis agreement from the dialysis clinic. Review of R32's Dialysis Communication Sheets from September 2022 to 02/15/23 revealed 19 communication sheets were missing for the following dates: 09/06/22, 09/08/22, 09/10/22, 09/13/22, 09/17/22, 09/20/22, 09/22/22, 09/27/22, 10/04/22, 10/22/22, 11/05/22, 11/22/22, 11/24/22, 11/29/22, 12/17/22, 01/10/23, 01/21/23, 01/24/23, 01/26/23. On 02/15/23 at 08:49 AM R32 sat at the dining table in his wheelchair visiting with another resident. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 01:27 PM Licensed Nurse (LN) H stated when R32 was sent for his dialysis the communication sheet and book were always sent with him. LN H stated the book would return with the resident, but the communication sheet did not always get returned. On 02/16/22 at 01:45 PM Administrative Nurse E stated the dialysis clinic R32 went to did the dialysis agreement with the resident and not the facility, so they did not have a signed agreement. The dialysis communication sheets were sent with R32 in his yellow dialysis folder each time he went to his dialysis appointments, but they do not always return with him. Administrative Nurse E stated the facility calls the clinic to request the communication form, but they are not always received. The End-Renal Disease, Care of a Residents care with policy revised September 2010 documented: agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care would be managed including: how the care plan will be developed and implemented; how information will be exchanged between the facilities; and responsibility for waste handling, sterilization and disinfection of equipment. The facility failed to ensure collaberation with the dialysis provider for R32 and failed to ensure that dialysis communication sheet was completed/returned with R32 after returning from the dialysis clinic. This left R32 at risk for improper care and treatment needed for dialysis.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 45668 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to have sufficient staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promoted each residents' rights, physical, mental and psychosocial well-being. Findings Included: - A review of the facility's Posted Staffing and Working Schedule from 08/01/22 through 02/14/23 revealed the facility had low staffing for 2022 on the following 10 days: 09/01, 09/02, 09/03, 09/04, 09/25, 11/21, 12/04, 12/06, 12/11, and 12/13. A video, provided anonymously to the State Agency (SA), taken on 01/21/23 at 07:02 PM revealed R30 sat on the ground in the hallway outside his room. R30 sat on his knees on a bedsheet, without pants, signaling to someone in the hallway. Another video provided to the SA anonymously, revealed on 02/10/23 at 07:04 PM R30 was with staff in his room. Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) N stood over R30 as he lay partially on the end of a mattress on the floor. The video revealed CMA R held R30's left arm, gestured to CNA N who then grabbed R30's right arm. Both staff then pulled R30's arms upwards in a hyperextended position (extend a limb or joint beyond its normal limits) over his head as they pulled him back towards the wall on his floor mattress. Staff placed a blanket over him. The video showed R30 attempted to get up from the mattress on the floor as staff turned out the light, exited his room, shut the door and walked away. The video showed R30's call light was under his bed, towards the end of the bed and out of R30's immediate reach from his position on the mattress on the floor. On 02/13/23 at 08:33 AM R12 reported the facility often was short on staff or used agency staff, who would not assist the resident's appropriately as they should. He stated the Weekend Managers left early in the afternoon and did not supervise the staff. He stated it took forever for staff to respond to call lights and the facility often overwork the staff that do come to work. He stated most of the good staff left and now they mostly used agency staff. He also noted that staff were not available on weekend to disperse resident funds. (See Citation F567) On 02/13/23 at 08:45 AM R10 reported the facility often was short on staff, resulting in him having to hit his call light multiple times. He stated even with the agency staff working it still seemed like his cares either take too long to complete or his was waiting on staff to answer his call light. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/14/23 at 03:38 PM, Resident Council members reported the facility had struggled to maintain staff and relied heavily on Agency staff to fill the holes. The council members reported sometimes staff is so short that it causes long wait times for cares, unanswered call lights, and fears that the residents may be left on the ground if they fell . The resident stated the weekend agency staff are sadistic. The council reported staffing was sometimes so short they nicknamed it the skeleton crew. They also noted that activities are not always completed on weekend due to no Activity Coordinator. (See Citation F679) On 02/16/23 at 12:50 PM Licensed Nurse (LN) H stated that a few months ago agency staff would continually call off resulting in short staffing, and Administrative Nurse E had to come in to fill the holes. On 02/16/23 at 12:55 PM LN G stated the facility was not providing restorative services (services that increase strength and mobility by administering exercises designed by the nursing or rehabilitation department) at this time due the facility did not have a Restorative Aide. (See Citation F688) On 02/16/23 at 03:21 PM, CNA N stated during the incident on 02/10/23 she had to go to another hall and ask CMA R to assist her with moving R30 back to his bed. She stated the resident required two staff to move him to his bed. She stated that staff usually would have to move him by grabbing his arms and legs and lifting him to the bed. She reported that staff had to place him on his floor mattress because he would repeatedly get out of bed. She reported that he had repeated behaviors of crawling out of bed and was not sure what he needed. She stated that staff could not continually watch him and take care of the other residents. On 02/16/23 at 02:51 PM, CMA R stated that during the incident on 02/10/23 he was asked to assist moving R30 back to his bed from the hallway. He stated that staff found R30 crawling on the floor outside his room and needed assistance putting him back in his bed. He stated that staff often have to drag in back into his room. CMA R stated that he was passing medication in another hall and staff called for assistance. He stated that staff left R30 on his floor mattress due to him getting out of bed, crawling out, or falling out of bed. He stated the facility did not have enough staff to continually watch R30 or provide one to one supervision. He stated that he had to step away from administering his medication to fill in for the CNA staff. He stated that it would cause issues with his med pass. On 02/16/23 at 02:55 PM, Administrative Nurse E stated the facility did have a mass turnover of staff and a change in leadership. She stated if there was a shortage of staff or call off she would come in to work as a direct care staff. A review of the facility's Staffing Information revised 11/2022 noted that the facility must maintain staffing that meets regulatory requirement. The policy noted the facility must document staffing numbers (including contract staff), absences, total number of staff, and actual hours worked to ensure adequate coverage. The facility failed to have sufficient staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promoted each residents' rights, physical, mental and psychosocial well-being.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 48 residents. The sample included 16 residents with two residents reviewed for behaviors. Based on observation, record review, and interview, the facility failed to provide behavioral care related monitoring and services for Resident (R) 38, who wandered into other resident's rooms. This deficient practiced placed R38 at risk for risk for impaired ability to achieve and/or maintain her highest practicable level of physical and emotional wellbeing. Findings included: - The electronic medical record (EMR) for R38 documented diagnoses of: senile degeneration of the brain (memory loss, difficulty concentrating, finding it hard to carry out familiar daily task, struggling to follow a conversation or find the right word, being confused about time and place, and mood changes), neurocognitive disorder, pseudobulbar affect (a condition that's characterized by episodes of sudden uncontrollable and inappropriate laughing or crying). The Admission Minimum Data Set (MDS) dated [DATE] documented R38 had both long and short-term memory problem. R38 had moderately impaired cognitive skills for daily decision-making skills. R38 showed signs and symptoms of delirium (sudden severe confusion, disorientation and restlessness) with inattention that was present and fluctuated. R38 displayed daily behaviors that significantly interfered with residents in activities or social interaction. R38 significantly intruded on the privacy of others and wandered daily. The ADL Care Area assessment dated [DATE] documented R38 required supervision for ADL except for bathing, which required total assistance. Supervision was required due to severe cognitive impairment and lack of safety awareness. R38 was on hospice services and decline in self-care ability was anticipated. The Baseline Care Plan initiated 01/24/23 did not have a care area specific to dementia care. The Behavior Care Plan initiated 01/21/23 directed staff to minimize potential for the resident's disruptive behaviors by offering tasks which divert attention. Staff were to provide a program of activities that was of interest and accommodates resident's status. The plan indicated that R38 was at risk for wandering and elopement. The plan indicated that that R38's wandering behaviors may be attributed to her need to use the bathroom. The plan instructs staff to quietly ask her I she needed assistance. The plan noted that staff should offer walks, pictures, signs or memory boxes for distraction. The plan noted that R38 might wander into peer's room and instructs staff to redirect her or offer her another place to go. On 02/14/23 at 11:35 AM R38 wandered in and out of R2's (a severely cognitive impaired resident) room. On 02/13/23 at 08:30 AM R38 sat on her bed pushing the buttons on her electric lift bed. R38 would bounce up and down as she pushed the buttons. At 11:45 AM R38 was still in her bed. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/23 at 01:15 PM R38 wandered the dementia care unit. R38 went into R31's (severely cognitive impaired resident with a history of aggressive behaviors) while he slept, without staff supervision. R31 then exited the room after four minutes and walked down the hallway towards the dining room. R38 then walked into R36's (a severely cognitive impaired resident with a history of aggressive behaviors) room. R36's became anxious and repeatedly screamed for help. R36 exited the room and continued walking down the hallway towards her room. At 01:39PM R38 reentered R36's room resulting in R36 calling her a curse word. On 02/14/23 at 03:01AM, Certified Medication Aide (CMA) S stated staff attempted to keep the residents engaged with activities and groups, but often there were times in between cares that some of the residents wandered. R38 was often difficult to keep engaged because she often left activities and wandered. She stated R38 did well with sensory objects and had a special board in her room. On 02/16/23 at 03:30 PM Administrative Nurse E sated the staff should provide structure and activities for the residents on the dementia care unit. She stated many of the residents would often respond well to music, movies, and social groups. The Dementia- Clinical Protocol policy revised 11/2018 indicated the facility will provide a safe, supportive, and therapeutic plan for residents with dementia related illness. The policy indicated that facility will strive to optimize familiarity through consistent staff assignments. The policy noted that individualized care plans and interventions will be implemented to minimize the risks for dementia residents. The facility failed to provide behavioral care and monitoring and services for R38, who wandered into other resident's rooms. This deficient practiced placed R38 at risk for risk for impaired ability to achieve and/or maintain her highest practicable level of physical and emotional wellbeing.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 45668 The facility identified a census of 48 residents. The sample include 16 residents with one resident reviewed for dementia (progressive mental disorder characterized by failing memory, confusion). Based on observation, record review, and interviews, the facility failed to follow interventions to manage and care for R30 's behavioral needs related to his dementia. This deficient practice placed 30 residents at risk for preventable accidents and decreased psychosocial well-being. Findings included: - The Medical Diagnosis section within R30's Electronic Medical Records (EMR) included diagnoses of alcohol induced dementia, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), muscle weakness, lack of coordination, restlessness, and agitation. R30's Significant Change Minimum Data Set (MDS) completed 12/08/22 noted a Brief Interview for Mental Status (BIMS) could not be completed due to severe cognitive impairment. The MDS indicated R30 had verbal behaviors directed towards others and himself. The MDS noted his behaviors significantly interfered with his care. The MDS noted that he had a history of rejecting care. The MDS noted he required extensive assistance from two staff for bed mobility, transfers, dressing, personal hygiene, toileting, and bathing. The MDS noted he required supervision and one-person physical assist from one staff member, and he required a wheelchair for mobility. The MDS indicated he received hospice services. A review of R30's Cognitive Loss/Dementia Care Area Assessment (CAA) completed 12/08/22 indicated R30 had a diagnosis of dementia. The CAA noted he had a decreased ability to make himself understood, decline in continence, and needed assistance with his Activities of Daily Living (ADL). A review of R30's Communication CAA completed 12/08/22 indicated he had impairments related to expression, reception of information, difficulty pronouncing and describing, and had difficulty putting sentences together. A review of R30's Behavior CAA completed 12/08/22 indicated he had a history of rejection of care and verbal behaviors towards others. A review of R30's Care Plan initiated 09/09/19 for Cognitive Function indicated that R30 had impaired cognitive function related to his medical diagnoses and impaired thought process. The plan noted he was at risk for abuse and instructed staff to approach him in a calm manner, address him by his name, and provide him personal space (11/05/20). The plan indicated he should be provided a home-like environment (07/19/21). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R30's Care Plan initiated 08/15/22 for Advanced Directives indicated R30 received hospice services. The plan indicated hospice would supply durable medical equipment, medications related to his diagnosis, skin treatments, incontinence supplies, and other treatment/supplies related to his comfort. The care plan instructed staff should notify hospice if unable to manage his behaviors (08/19/22). A review of R30's Care Plan initiated 03/27/19 for Behaviors instructed staff to monitor his behaviors and attempt to determine a cause with consideration to the location, time of day, persons involved, and situation (03/27/19). The plan instructed staff to offer smoke breaks, go outside, and call his daughter when agitated (07/13/21). A review of R30's EMR under Progress Note on 01/22/23 at 04:20 PM indicated R30 was in the dining room and made several attempts to jump out of his Broda chair. The note indicated staff placed him on his floor mattress and left him in his room. The note indicated R30 then crawled out into the hallway crying for help. The note lacked notification to hospice or intervention attempted to address his crawling. A review of R30's Progress Note on 01/22/23 at 12:17 AM indicated R30 had periods of extreme agitation, fighting with staff members, and repeated climbing out of his Broda chair to the floor. The note indicated he acquired multiple skin tears due to his behaviors. The note indicated he received Haldol (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions) per medical providers orders. The note lacked documentation hospice was notified. A review of R30's Progress Note for 01/29/23 indicated he had extreme agitation but lacked documentation showing hospice was notified. The note lacked documentation of interventions provided by staff or staff effort to assess and/or evaluate R30's needs. A review of R30's Progress Note for 01/31/23 indicated he had extreme agitation but lacked documentation showing hospice was notified. The note lacked documentation of interventions provided by staff or staff effort to assess and/or evaluate R30's needs. A review of R30's Progress Note for 02/08/23 indicated he had extreme agitation but lacked documentation showing hospice was notified. The note lacked documentation of interventions provided by staff or staff effort to assess and/or evaluate R30's needs. A video provided to the SA anonymously, revealed on 02/10/23 at 07:04 PM R30 with staff in his room. Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) N stood over R30 as he lay partially on the end of a mattress on the floor. The video revealed CMA R held R30's right arm, gestured to CNA N who then grabbed R30's left arm. Both staff then pulled R30's arms upwards in a hyperextended position (extend a limb or joint beyond its normal limits) as they pulled him back towards the wall on his floor mattress. Staff placed a blanket over him. The video showed R30 attempted to get up from the mattress on the floor as staff turned out the light, exited his room, shut the door and walked away. The video showed R30's call light was under his bed, towards the end of the bed and out of R30's immediate reach from his position on the mattress on the floor. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's clinical record lacked evidence the facility notified hospice regarding R30's behaviors in an effort to obtain assistance with oversight, pain management and evaluation of resident comfort and needs. On 02/15/23 at 10:04 AM, CNA P stated the facility staff struggled to address R30's behaviors and often overlook them. She stated the last time she was in the facility she asked for assistance with R30's behaviors and staff would tell her that's just him and would not help. She stated she even asked Social Services X for assistance and was told that's just [R30]. She stated when she cared for R30 she frequently offered him snacks, escort him around the facility, give him smoke breaks, and spend time with him to keep him calm. She stated the facility often would not take the time with him and by the time she came to care for him, he would already be agitated. She stated the facility would just hand him over upset and expect hospice to calm him down. She stated she would activate his call light and staff would not respond to assist during his behavioral episodes. On 02/15/23 at 03:21 PM, Social Service Y reported hospice was not contacted about R30's behaviors on 02/10/23. She stated the facility was responsible for updating hospice for changes in R30's behavior or cares. She stated that the hospice staff would adapt to R30's needs to find out what was causing his behaviors. On 02/16/23 at 03:21 PM, CNA N reported that R30 often would have to be brought back to his bed due to him attempting to leave his room. She stated she usually had to grab his arm or a leg to carry him back to his bed. She stated he required multiple staff to assist with getting back to his room due to his behaviors. She reported staff had to place him on his floor mattress because he would repeatedly get out of bed. She reported he had repeated behaviors of crawling out of bed and did not know what he needed. On 02/16/23 at 03:51PM, CMA R stated during the incident on 02/10/23 he was asked to assist moving R30 back to his bed from the hallway. He stated the staff found R30 crawling on the floor outside his room and needed assistance putting him back in his bed. He stated the staff often have to drag him back into his room. CMA R stated he was passing medication in another hall and staff called for assistance. He stated that staff left R30 on his floor mattress due to him getting out of bed, crawling out, or falling out of bed. On 02/16/23 at 04:00PM, Licensed Nurse (LN) H stated R30 loved to be taken around the facility to see other residents. She stated he liked to go out smoking and watch sports. She stated R30's behaviors were usually the result of an unmet need such as needing to be taken to the restroom, taken to bed, or even just moved to a quite area to calm down. On 02/16/23 at 04:34PM Administrative Nurse E stated staff should be offering snacks, food, activities, smoke breaks, and ADL assistance to ensure his needs are being met. She stated the staff should also offer to call his daughter when he is upset. She stated most of his behaviors may be related to him not being able to communicate his needs. She stated the staff should talk slowly into his right ear and allow him time to respond. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dementia- Clinical Protocol policy revised 11/2018 indicated the facility will provide a safe, supportive, and therapeutic plan for residents with dementia related illness. The policy indicated that facility will strive to optimize familiarity through consistent staff assignments. The policy noted that individualized care plans and interventions will be implemented to minimize the risks for dementia residents. The policy noted a person-centered plan will be created and followed to provide the level of support needed to enhance cognition and manage behavioral symptoms. The facility failed follow interventions related R30 's dementia behavior needs. This deficient practice placed R30 at risk for impaired psychosocial wellbeing.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 48 residents. The sample included 16 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities for physician hold parameter for Resident (R) 19's and R26's hypertensive medication (class of medication used to treat high blood pressure). This deficient practice placed these residents at risk for unnecessary medication administration and possible harmful side effects. Findings included: - R19's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition, and no staff interview was completed. The MDS documented R19 required limited assistance of one staff member for activities of daily living (ADL). The MDS documented no weight loss during look back period. The MDS documented R19 had received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment testing) and other mental emotional conditions) daily during the seven day look back period. The Quarterly MDS dated [DATE] documented R19 with severely impaired cognition. The MDS documented that R19 required extensive assistance of one staff member for ADL. The MDS documented R19 had a weight loss during the look back period, but was not on a physician ordered weight loss program. The MDS documented R19 had received antidepressant and antipsychotic medications for seven days during the look back period. R19's Psychotropic Drug Use Care Area Assessment (CAA) dated 06/28/22 documented R19 received psychotropic (altering mood or thought) medication daily. R19's Care Plan dated 07/16/19 documented staff would monitor R19's blood pressure and notify the physician of any abnormal readings. Review of the EMR under Orders tab revealed physician orders: Amlodipine besylate tablet (antihypertensive medication) 10 milligrams give one tablet by mouth one time a day for heart/ blood pressure related to hypertension. Hold if systolic blood pressure (BP) (relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) less than (<) 110 millimeters of mercury (mmHg) and diastolic BP (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) is < 65mmHg or the heart rate (HR) is < 60 beats per minute dated 01/21/22. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR under Reports tab for Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 08/01/22 to 02/12/23 revealed: Amlodipine besylate tablet 10mg, give 10 mg by mouth daily, for HTN was administered outside physician ordered parameters on the following dates: 08/31/22, 09/03/22, 09/05/22, 09/09/22, 09/15/22, 09/18/22, 12/06/22, 12/10/22, 12/18/22, 01/03/23, and 02/09/23. Review of the Monthly Medication Review (MMR) from August 2022 to January 2023 lacked evidence the pharmacist identified and notified the facility of R19s antihypertensive medication administered outside of physician ordered parameters within those dates. On 02/13/23 at 11:35 AM R19's breakfast tray with lid sat on the bedside table next to the bed, no cups of fluid noted on the tray. R19 laid on the bed with blankets pulled to chest height. On 02/16/23 at 01:03 PM Licensed Nurse (LN) H stated the Certified Medication Aide (CMA) was usually the staff who administered the antihypertensive medication to R19. LN H stated the CMAs obtained the BP and pulse, and when it was outside the physician ordered parameters the CMAs would hold the medication and notify the nurse. LN H stated the nurse would then notify the physician. LN H stated she did not have any thing to do with the MMR's. On 02/16/23 at 01:50 PM Administrative Nurse E stated if an outside the physician-ordered BP parameter was documented on the MAR an alert would turn red and the nurse must clear the alert. Administrative Nurse E stated the CP does not specifically focus on the outside parameter BP or pulses. Administrative Nurse E stated the MMR are emailed to her, she printed the MMRs then had the physician review any irregularities noted and the charge nurses make the changes for any new orders. On 02/20/23 at 04:20 PM CP GG stated she reviewed every resident that was in the facility for that month reviewed. CP GG stated she reviewed the resident's clinical record for new orders, current labs, appropriate diagnosis, out of parameter vital signs and blood sugars. CP GG stated the MMRs are emailed to the facility administrator, director of nursing, assisted director of nursing and director of operations monthly. The facility's Pharmacy Services-Role of the Consultant Pharmacist policy last revised April 2019 documented the CP would provide specific activities related to medication regimen review including a documented review of the medication regimen of each resident at least monthly, or more frequently, under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident -specific documentation in the medical record, as indicated. The facility failed to ensure the CP identified and reported irregularities when physician ordered parameters antihypertensive medication for R19 were not followed. This had the potential for adverse of unnecessary medication administration or possible harmful side effects. 47834 - R26's Electronic Medical Record (EMR) documented diagnoses of essential hypertension and dementia (progressive mental disorder characterized by failing memory, confusion). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of one which indicated severe cognitive impairment. The Quarterly MDS dated [DATE], documented a BIMS score of zero which indicated severe cognitive impairment. R26 received diuretic (medication to promote the formation and excretion of urine) medications seven days in the seven-day look back period. The Cognitive Impairment/Dementia Care Area Assessment (CAA) dated 09/12/22, documented R26 had a diagnosis of dementia. The Care Plan 12/11/22 documented R26 had a diagnosis of hypertension and took lisinopril-hydrochlorothiazide (antihypertensive medication) daily. The Care Plan directed staff obtained blood pressure readings, gave antihypertensive medications as ordered, and monitored for side effects such as orthostatic hypotension (blood pressure dropping with change of position) and increased heart rate. The Orders tab of R26's EMR documented an order with a start date of 11/15/22 for lisinopril-hydrochlorothiazide 20-25 milligrams (MG) daily related to hypertension. The order documented that the lisinopril-hydrochlorothiazide was held if the systolic (top number, the force your heart exerts on the walls of your arteries each time it beats) was below 110 millimeters of mercury (mmHg), the diastolic (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was below 65 mmHg, or the pulse was below 60 beats per minute (BPM). and staff notified the physician and documented the response. Review of R26's Medication Administration Record (MAR) and Vitals tab for 12/13/22 to 02/13/22 revealed lack of documentation the staff obtained the resident's blood pressure and pulse for monitoring before the administration of lisinopril-hydrochlorothiazide. Review of the Monthly Medication Review (MMR) from December 2022 to January 2023 lacked evidence the pharmacist identified and notified the facility of the lack of monitoring R26's blood pressure and pulse despite physician-ordered parameters. On 02/14/23 at 11:35 AM, R26 sat on the couch near the nurses' station, appeared comfortable. On 02/16/23 at 08:44 AM, Certified Medication Aide (CMA) S stated that there should have been an area under the order to input the vitals on the MAR. CMA S stated she contacted the nurse to find out if the medication needed to be held. On 02/16/23 at 01:03 PM Licensed Nurse (LN) H stated the Certified Medication Aide (CMA) was usually the staff who administered the antihypertensive medication to R26. LN H stated CMAs obtained the BP and pulse, when outside the physician ordered parameters, the CMAs would hold the medication and notify the nurse. LN H stated the nurse would then notify the physician. LN H stated she did not have any thing to do with the MMR's. On 02/16/23 at 01:50 PM Administrative Nurse E stated if an outside the physician-ordered BP parameter was documented on the MAR an alert would turn red and the nurse must clear the alert. Administrative Nurse E stated the CP does not specifically focus on the outside parameter BP or pulses. Administrative Nurse E stated the MMR are emailed to her, she printed the MMRs then had the physician review any irregularities noted and the charge nurses make the changes for any new orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/23 at 04:20 PM CP GG stated she reviewed every resident that was in the facility for that month reviewed. CP GG stated she review the resident's clinical record for new orders, current labs, appropriate diagnosis, out of parameter vital signs and blood sugars. CP GG stated the MMRs are emailed to the facility administrator, director of nursing, assisted director of nursing and director of operations monthly. The facility's Pharmacy Services-Role of the Consultant Pharmacist policy last revised April 2019 documented the CP would provide specific activities related to medication regimen review including a documented review of the medication regimen of each resident at least monthly, or more frequently, under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident -specific documentation in the medical record, as indicated. The facility failed to ensure the CP identified and reported irregularities when physician ordered parameters and vital signs for antihypertensive medications for R26 were not followed. This had the potential for adverse of unnecessary medication administration or possible harmful side effects.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 48 residents. The sample included 16 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the staff followed physician ordered hold parameters for Resident (R) 19's and R26's hypertensive medication (class of medication used to treat high blood pressure). The facility further failed to follow a physician order to obtain lab work ordered for R42. This deficient practice placed these residents at risk for unnecessary medication administration thus leading to possible harmful side effects. Findings included: - R19's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypertension (elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition, and no staff interview was completed. The MDS documented R19 required limited assistance of one staff member for activities of daily living (ADL). The MDS documented no weight loss during look back period. The MDS documented R19 had received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment testing) and other mental emotional conditions) daily, during the look back period. The Quarterly MDS dated [DATE] documented R19 with severely impaired cognition. The MDS documented that R19 required extensive assistance of one staff member for ADL. The MDS documented R19 had a weight loss during the look back period, but was not on a physician ordered weight loss program. The MDS documented R19 had received antidepressant and antipsychotic medications daily, during the seven day look back period. R19's Psychotropic Drug Use Care Area Assessment (CAA) dated 06/28/22 documented R19 received psychotropic (altering mood or thought) medication daily. R19's Care Plan dated 07/16/19 documented staff would monitor R19's blood pressure and notify the physician of any abnormal readings. Review of the EMR under Orders tab revealed the following physician orders: Amlodipine besylate tablet (antihypertensive medication) 10 milligrams give one tablet by mouth one time a day for heart/ blood pressure related to hypertension. Hold if systolic blood pressure (BP) (relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) less than (<) 110 millimeters of mercury (mmHg) and diastolic BP (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) is < 65mmHg or the heart rate (HR) is < 60 beats per minute dated 01/21/22. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR under Reports tab for Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 08/01/22 to 02/12/23 revealed: Amlodipine besylate tablet 10mg give 10 mg by mouth daily for HTN was administered outside physician ordered parameters on the following dates: 08/31/22, 09/03/22, 09/05/22, 09/09/22, 09/15/22, 09/18/22, 12/06/22, 12/10/22, 12/18/22, 01/03/23, and 02/09/23. On 02/13/23 at 11:35 AM, R19's breakfast tray with lid sat on the bedside table next to the bed, with no cups of fluid noted on the tray. R19 laid on the bed with blankets pulled to chest height. On 02/16/23 at 01:03 PM Licensed Nurse (LN) H stated the Certified Medication Aide (CMA) was usually the staff who administered the antihypertensive medication to R19. LN H stated the CMAs obtained the BP and pulse and when it was outside the physician ordered parameters, the CMAs would hold the medication and notify the nurse. LN H stated the nurse would then notify the physician. On 02/16/23 at 01:50 PM Administrative Nurse E stated if an outside the physician-ordered BP parameter was documented on the MAR, an alert would turn red and the nurse must clear the alert. Administrative Nurse E stated the charge nurse would have to follow up on the out of parameter BP or pulse and notify the physician. The facility's Physician Services policy last revised April 2013 documented the medical care of each resident was under the supervision of a licensed physician. The resident's attending physician would participate in the resident's assessment care planning, monitoring changes in resident's medical status, provided consultation or treatment when called by the facility and overseeing a relevant plan of care for the resident. The facility failed to ensure the physician ordered parameters for antihypertensive medication for R19 were followed. This had the potential for adverse of unnecessary medication administration or possible harmful side effects. - R42's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dysphagia (swallowing difficulty). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented that R42 required extensive assistance of one staff member for activities of daily living (ADL). The MDS documented R42 had received antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) and anticoagulant medication (class of medications used to prevent the formation of blood clots) daily, during the seven day look back period. R42's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/22/22 documented R42 received antidepressant medication daily. R42's Care Plan dated 12/21/22 directed staff to monitor lab results, especially liver and kidney function as ordered by the physician. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed under Miscellaneous tab a Monthly Medication Review (MMR) scanned into the EMR dated 11/16/22 with an order for lab, related to R42's diabetes mellitus, to be completed on the next time lab came to the facility. The clinical record lacked the results from the lab ordered. The facility was unable to provide the lab results as ordered by the physician. On 02/14/23 at 09:00 AM R42 sat at the dining room table, consumed 75% of breakfast without assistance. R42 had two small cups and coffee cups of fluid with thin consistency on the table in front of him. On 02/16/23 at 01:03 PM Licensed Nurse (LN) H stated she was not aware of any lab work ordered for R42. On 02/16/23 at 01:50 PM Administrative Nurse E stated R42 had been transferred to the hospital after the physician had ordered that lab work. Administrative Nurse E stated after R42 had returned to the facility that lab ordered had not been clarified with the physician. The facility's Physician Services policy last revised April 2013 documented the medical care of each resident was under the supervision of a licensed physician. The resident's attending physician would participate in the resident's assessment care planning, monitoring changes in resident's medical status, provided consultation or treatment when called by the facility and overseeing a relevant plan of care for the resident. The facility failed to ensure a physician order for lab work for diabetes mellitus had been completed as ordered for R42. This had the potential for adverse of unnecessary medication administration or possible harmful side effects. 47834 - R26's Electronic Medical Record (EMR) documented diagnoses of essential hypertension and dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of one which indicated severe cognitive impairment. The Quarterly MDS dated [DATE], documented a BIMS score of zero which indicated severe cognitive impairment. R26 received diuretic (medication to promote the formation and excretion of urine) medications seven days in the seven-day look back period. The Cognitive Impairment/Dementia Care Area Assessment (CAA) dated 09/12/22, documented R26 had a diagnosis of dementia. The Care Plan 12/11/22 documented R26 had a diagnosis of hypertension and took lisinopril-hydrochlorothiazide (antihypertensive medication) daily. The Care Plan directed staff obtained blood pressure readings, gave antihypertensive medications as ordered, and monitored for side effects such as orthostatic hypotension (blood pressure dropping with change of position) and increased heart rate. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Orders tab of R26's EMR documented an order with a start date of 11/15/22 for lisinopril-hydrochlorothiazide 20-25 milligrams (MG) daily related to hypertension. The order documented the lisinopril-hydrochlorothiazide was held if the systolic (top number, the force your heart exerts on the walls of your arteries each time it beats) was below 110 millimeters of mercury (mmHg), the diastolic (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was below 65 mmHg, or the pulse was below 60 beats per minute (BPM). and staff notified the physician and documented the response. Review of R26's Medication Administration Record (MAR) from 12/13/22 to 02/13/22 revealed lack of evidence/documentation the staff obtained R26's blood pressure and pulse for monitoring before the administration of lisinopril-hydrochlorothiazide. On 02/14/23 at 11:35 AM, R26 sat on the couch near the nurses' station, appeared comfortable. On 02/16/23 at 08:44 AM, Certified Medication Aide (CMA) S stated that there should have been an area under the order to input the vitals on the MAR. CMA S stated she contacted the nurse to find out if the medication needed to be held. On 02/16/23 08:44 AM, Licensed Nurse (LN) I stated that there should have been an area under the order to input the vitals on the MAR. LN I stated that blood pressure and pulse should have been documented in the progress notes, if it was not on the MAR/Treatment Administration Record (TAR). He stated he had not noticed any residents that did not have parameters on the MAR/TAR for the blood pressure. LN I stated he would notify the physician if the medication was held. On 02/16/23 at 02:30 PM Administrative Nurse E stated if a medication had an ordered parameter, the MAR did not alert staff if the vital signs were outside of the ordered parameter. Administrative Nurse E stated she, along with the provider, had reviewed the residents' charts and set parameters in the EMR under the vital tab. She stated she expected staff to follow the physician ordered parameters. The facility's Physician Services policy last revised April 2013 documented the medical care of each resident was under the supervision of a licensed physician. The resident's attending physician would participate in the resident's assessment care planning, monitoring changes in resident's medical status, provided consultation or treatment when called by the facility and overseeing a relevant plan of care for the resident. The facility failed to monitor R26's blood pressure and pulse before the administration of antihypertensive medication as ordered by physician. This deficient practice had the risk for unnecessary medication use and unwarranted physical complications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47834 The facility identified a census of 48 residents. The sample included 16 residents, with five residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 26 had an appropriate diagnosis for antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) medication usage. This deficient practice had the risk for unnecessary medication use and unwarranted physical complications. Findings included: - R26's Electronic Medical Record (EMR) documented diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia [psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought] bipolar type (includes episodes of mania [mood characterized by an unstable expansive emotional state, extreme excitement, hyperactivities] and sometimes major depression [major mood disorder]). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of one which indicated severe cognitive impairment. R26 had physical behavioral symptoms directed towards others one to three days and other behavioral symptoms not directed toward others four to six days in the look back period. R26 received antipsychotic, antianxiety (class of medications that calm and relax people with excessive anxiety [mental or emotional reaction characterized by apprehension, uncertainty and irrational fear], nervousness, or tension), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications seven days in the seven-day look back period. The Quarterly MDS dated [DATE], documented a BIMS score of zero which indicated severe cognitive impairment. R26 had verbal behavioral symptoms directed towards others one to three days in the look back period. R26 received antipsychotic, antianxiety, and antidepressant medications daily in the seven-day look back period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 09/12/22, documented R26 had a diagnosis of dementia. The Behavioral Symptoms CAA dated 09/12/22, lacked analysis of findings. The Psychotropic (any drug that affects brain activities associated with mental processes and behavior) Drug Use CAA dated 09/12/22, documented R26 had potential for side effects or mood/behavior changes and noted she received Seroquel (antipsychotic medication). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Antipsychotic Care Plan 12/08/21 documented R26 was at risk for adverse side effects related to use of antipsychotic medications and directed staff to administer medications as ordered and monitor behaviors. The Orders tab of R26's EMR documented an order with a start date of 11/08/21 for Seroquel 50 milligrams (mg) at bedtime related to schizoaffective disorder bipolar type. R26's EMR revealed the following: A Physician's Progress Note on 09/12/22 documented R26 was stable and had no indications of distress or discomfort during that encounter. The note documented R26 received Seroquel and had a diagnosis of dementia. The Note did not address an appropriate diagnosis for Seroquel and lacked documentation or evidence of a schizoaffective diagnosis. A Psychiatric Evaluation on 09/13/22 documented R26 was seen for an initial psychiatric evaluation. She had significant history of major depressive disorder, anxiety disorder, and mood disorder. R26 was not visibly anxious or in distress. Staff reported nothing acute and denied any delusional thought content. The Evaluation documented R26 had no psychotic symptoms noted or reported. The Evaluation lacked documentation or evidence of a schizoaffective diagnosis. A Physician's Progress Note on 01/09/23 documented R26 was stable and had no indications of distress or discomfort during that encounter. The Note documented R26 received Seroquel and had a diagnosis of dementia. The Note did not address an appropriate diagnosis for Seroquel and lacked documentation or evidence of a schizoaffective diagnosis. A Psychiatric Evaluation on 01/10/2023 documented R26 was seen for a monthly psychiatric follow-up. R26 was not visibly anxious or in distress. Staff denied any delusional thought content. The Evaluation documented R26 had no psychotic symptoms noted or reported. The Evaluation lacked documentation or evidence of a schizoaffective diagnosis. R26's medical record lacked evidence of physician's documentation related to the schizoaffective disorder added to R26's diagnoses in January 2023. The clinical record also lacked physician documentation regarding all interventions, including nonpharmacological attempts and previous medications attempted in order provide a rationale for the continued use of the Seroquel in the presence of dementia despite the risks. The facility was unable to locate the information in the clinical record or provide upon request. On 02/14/23 at 11:35 AM, R26 sat on the couch near the nurses' station, with no behaviors noted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 12:35 PM, Administrative Nurse E stated the new medical director was much more involved and reviewed the medical records and current diagnoses for the residents. She said the diagnosis for the schizoaffective disorder was provided by the new medical director after the comprehensive exam was completed. Administrative Nurse E said she was the one who entered the diagnoses once the physician gave the order. She stated the diagnosis may have been pulled forward from some old hospital paperwork or the psychiatric provider but confirmed it was not clearly documented in the resident's chart where the diagnosis came from. Administrative Nurse E reviewed R26's chart and verified she was unable to see in the psychiatric visit notes or in the provider notes documentation related to a diagnosis of schizoaffective disorder. She said she knew antipsychotics were only appropriate for use when indicated by medical need for reasons such as psychosis, schizophrenia, or some other specific disorders. Administrative Nurse E verbalized uncertainty regarding the requirements when antipsychotic medications were used in the presence/treatment of dementia but stated she would discuss the requirements with the medical director. She reported R26's behaviors and quality of life had improved, and the resident was adjusting well and had fewer behavioral episodes. The facility's Antipsychotic Medication Use policy, revised December 2016, directed antipsychotic mediations may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptom have been identified and addressed. Antipsychotic medications shall generally be used only for certain conditions/diagnoses as documented in the record including schizoaffective disorder. Diagnoses alone do not warrant the use of antipsychotic medications. In addition to diagnosis/criteria, antipsychotic medications were generally only considered if the behavioral symptoms presented a danger to the resident or others and the symptoms were identified as being due to mania or psychosis; or behavioral interventions had been attempted and included in the plan of care. The facility failed to ensure that R26 had an appropriate diagnosis for antipsychotic medication usage. This deficient practice had the risk for unnecessary medication use and unwarranted physical complications.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, record review, and interviews, the facility failed to provide Resident (R)42, who required thickened liquids, with the correct consistency as ordered. This deficient practice placed R42 at increased risk for adverse side effects of aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit) and dehydration. Findings included: - R42's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dysphagia (swallowing difficulty). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented that R42 required extensive assistance of one staff member for activities of daily living (ADL). R42's Nutritional Status Care Area Assessment (CAA) dated 12/22/22 documented R42 had a diagnosis of dysphagia. R42's Care Plan with revision date of 12/21/22 directed staff to provide R42 diet as ordered and nectar thickened liquids. Review of the EMR under Orders tab revealed the following physician orders: Diet order: regular diet with mechanical soft/ground meat texture, nectar thickened liquids and gravy on all meats dated 12/13/22. On 02/14/23 at 09:00 AM R42 sat at the dining room table, consumed 75% of breakfast without assistance. R42 had two small cups and coffee cups of fluid with thin consistency on the table in front of him. On 02/14/23 at 12:54 PM R42 sat on the side of the bed. He had a clear pitcher on the bedside table which contained clear, thin-consistency fluid. On 02/15/23 at 09:10 AM R42 sat on the side of the bed and ate a cup of applesauce. A clear cup, with a lid and straw, was half-full of clear, thin-consistency fluid on the bedside table in front of R42. On 02/15/23 at 01:28 PM Certified Nurse Aide (CNA) M stated R42 was on regular thin liquids. CNA M stated she would have to check R42's dietary slip to make sure what liquid consistency R42 had ordered. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/15/23 at 01:48 PM Dietary Staff BB stated she was not for sure what liquid consistency was ordered for R42 and said she would check his current diet order. Dietary Staff BB stated R42 was ordered a mechanical soft diet with nectar thickened liquids. On 02/16/23 at 01:03 PM Licensed Nurse (LN) H stated each resident's diet was located on the care plan which all staff had access to review, listed on the Medication Administration Record (MAR) which the nurse can review when passing medications. LN H stated the resident's diet could be found on the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change). On 02/16/23 at 01:50 PM Administrative Nurse E stated staff should review the current order on the dietary slip when passing trays to ensure the correct diet was served. The facility's Weight Assessment and Interventions policy last revised September 2008 documented the physician, and the multidisciplinary team would identify conditions such as chewing or swallowing abnormalities. The facility failed to provide R42, who required thickened liquids, with the correct consistency as ordered. This deficient practice placed R42 at increased risk for adverse side effects of aspiration pneumonia and dehydration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45668 The facility identified a census of 48 residents and one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to food storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns. Findings Included: - On 02/13/23 at 07:15 AM during an initial walkthrough of the kitchen's Dry Food storage room revealed an opened, half full can of lemon-lime soda of an undetermined age. On 02/13/23 at 07:40 AM an initial walkthrough of the dementia unit revealed the unit's ice bucket scoop left in the ice without a barrier to prevent contamination from the handle. On 02/14/23 at 10:20 AM a food service cart was left outside the kitchen entrance. The cart contained a two-gallon carton of milk which was left out on top of the cart. The milk was temperature tested at 11.3 degrees Celsius (52.34 degrees Fahrenheit) by Dietary Staff CC. He stated the milk should always be refrigerated or put in ice during meal service and returned to the kitchen for safe storage. The milk was discarded. On 02/14/23 at 08:05 AM Certified Medication Aide (CMA) S stated the ice scoop should not be left in the ice bucket, due to contamination. A review of the facility's Food Storage policy revised 10/2017 indicated all refrigerated foods must be maintained at or below 40 degrees Fahrenheit. The policy stated that all opened food must be labeled and properly stored in a manner that is sanitary and prevents contamination. The policy indicated that all food be received, stored, and handled following sanitary standards including maintaining storage containers, utensils, and equipment. The facility failed to maintain sanitary dietary standards related to food storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Park Post-Acute and Rehabilitation Center	6515 W 103rd Street Overland Park, KS 66212

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 48 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 38 had an order for hospice and failed to ensure collaboration of services, medication, and equipment provided to R38 from hospice. This deficient practice placed R38 at risk for missed opportunities for services and delayed treatment. Findings included: - The Electronic Medical Record (EMR) for R38 documented diagnoses of: senile degeneration of the brain (memory loss, difficulty concentrating, finding it hard to carry out familiar daily task, struggling to follow a conversation or find the right word, being confused about time and place, and mood changes), neurocognitive disorder (dementia), and pseudobulbar affect (a condition that's characterized by episodes of sudden uncontrollable and inappropriate laughing or crying). The Admission Minimum Data Set (MDS) dated [DATE] documented R38 had both long and short-term memory problem. R38 had moderately impaired cognitive skills for daily decision-making skills. R38 showed signs and symptoms of delirium (sudden severe confusion, disorientation and restlessness) with inattention that was present and fluctuated. R38 displayed daily behaviors that significantly interfered with residents in activities or social interaction. R38 significantly intruded on the privacy of others and wandered daily for R38. R38 used hospice services. The ADL Care Area assessment dated [DATE] documented R38 required supervision for ADL except bathing which required total assistance. Supervision was required due to severe cognitive impairment and lack of safety awareness. R38 was on hospice services and a decline in self-care ability was anticipated. R38's Care Plan revised 02/06/23 did not have a specific hospice service listed that included the name and contact information of the hospice service, the services and frequency provided, medications provided, and equipment provided. The Order Summary Report dated 02/15/23 lacked a physician's order for hospice services. On 02/14/23 at 11:35 AM R38 walked about the dementia unit and wandered into a male resident's room. On 02/14/23 at 01:39 PM R38 walked about the dementia unit and walked into another female residents' room and that resident told R38 to get out of her room. On 02/15/23 at 11:07 AM Certified Nurse Aide (CNA) O stated residents on hospice have a book that hospice provides that should say what services hospice provided. CNA O stated hospice provided briefs, the beds, and other equipment as far as she knew, and the hospice aide gave residents a bath twice weekly; usually the care plan would say which hospice service the resident was on. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/22 at 01:11 PM Licensed Nurse (LN) H stated each resident on hospice should have a plan of care in their care plan book, the list of medications they provide, the medical equipment provided. LN H stated residents on hospice should have an order and the hospice information in the care plan as far as what was provided by them. On 02/16/22 at 01:45 PM Administrative Nurse E stated R38 had a hospice order now. Administrative Nurse E stated R38's care plan should mention who provides her hospice services and how to contact them. The Hospice Program policy revise 07/2017 documented the facility would have an agreement with at least one Medicare -certified hospice to ensure that residents who wish to participate in a hospice program may do so. In general it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including the following: determining the appropriate hospice plan of care; changing the level of services provided when it is deem appropriate; providing medical direction, nursing and clinical management of the terminal illness; providing spiritual, bereavement and/or psychosocial counseling and social services as needed; and providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility failed to ensure R38 had a physician's order for hospice and failed to ensure collaboration of services, medication and equipment provided to R38 and failed to provide a hospice services plan of care. This deficient practice placed R38 at risk for missed opportunities for services and delayed treatment.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41037 The facility identified a census of 48 residents. Based on observations, record review, and interviews, the facility failed to maintain an effective Quality Assessment and Assurance (QAA) program to identify quality issues and develop Performance Improvement Plans (PIPs). This deficient practice placed the residents at risk for a decrease in quality of care. Findings Included: - Based on observation, record review, and interviews, the facility failed to ensure Residents (R)25, R30, R39, and R40 received assistive cares in a dignified manner. This deficient practice placed the residents at risk for decreased psychosocial well-being. (Refer to F550) Based on record review and interviews, the facility failed to facilitate and ensure the resident council could meet regularly, which placed the residents at risk for isolation and unmet concerns related to life in the facility. (Refer to F565) Based on observation, record review, and interviews, the facility failed to maintain a safe, homelike environment. This deficient practice had the potential for decreased psychosocial well-being and impaired safety and comfort for the residents. (Refer to F584) Based on observation, record review, and interviews, the facility failed to ensure R30 remained free from staff to resident abuse, neglect, and mistreatment when Certified Medication Aide (CMA) M and Certified Nurse Aide (CNA) N each grabbed R30 by his hands, with his arms extended over his head, and drug him to position him on a mattress, which was on the floor next to R30's bed placed on the floor. CNA N placed a sheet over the resident, and both staff exited the room, turned the light out and shut the resident's door despite the resident being awake and active, on the mattress on the floor. (Refer to F600) Based on observation, interview, and record review, the facility failed to complete the Care Area Assessment (CAA) analysis of findings, related to a Comprehensive Minimum Data Set (MDS), for R42 and R44, to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. This deficient practice placed these residents at risk for a decreased in quality of care and treatment individualized to meet their needs. (Refer to F636) Based on observation, record review, and interviews, the facility failed to identify a significant change in the physical condition and complete a comprehensive Significant Change Minimum Data Set for R19. This deficient practice placed R19 at risk of alteration of care needed to maintain highest functional status. (Refer to F637) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, record review, and interviews, the facility failed to ensure staff used a gait belt when walking with R25, who required limited assistance (resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance) of one staff member for ambulation. This deficient practice placed R25 at risk of loss of functional abilities. (Refer to F676) Based on observation, record review, and interviews, the facility failed provide ongoing activities for the facility during weekends. This deficient practice placed 48 residents at risk for decreased psychosocial well-being. (Refer to F679) Based on observation, record review and interview, the facility failed to ensure R4 was monitored and received treatment and care for bowel management. The facility further failed to involve hospice for R30 to provide adequate end of life care. This deficient practice placed R4 at risk for constipation and R30 at risk for inadequate end of life care. (Refer to F684) Based on observation, record review, and interviews, the facility failed identify, consistently assess, and document R20's lower left leg wound. This deficient practice placed R20 at risk for impaired healing and infections. (Refer to F686) Based on observation, record review, and interview, the facility failed to ensure R39, who had a contracture (an abnormal permanent fixation of a joint), received appropriate restorative treatments to help maintain mobility. This placed R39 at risk for a decline in range of motion and decreased mobility. (Refer to F688) Based on observation, record review, and interviews, the facility failed to monitor R19's significant weight loss and implement recommendations to prevent further weight loss. This deficient practice placed R19 at risk of malnutrition and other negative outcomes. (Refer to F692) Based on observation, record review, and interview, the facility failed to provide a dialysis agreement for R32 and failed to ensure dialysis communication sheet were completed/returned with the resident after returning from the dialysis clinic. This left R32 at risk for risk for improper care and treatment needed for dialysis. (Refer to F698) Based on observation, record review, and interview, the facility failed to always have sufficient staff available to provide nursing and related services to meet the residents' needs safely and in a manner that promoted each residents' rights, physical, mental, and psychosocial well-being. (Refer to F725) Based on observation, record review, and interviews, the facility failed follow interventions related R30's behavioral needs. This deficient practice placed 30 residents at risk for preventable accidents and decreased psychosocial wellbeing. (Refer to F740) Based on observation, record review, and interview, the facility failed to provide dementia care related to monitoring and services for R38, who wandered into other resident's rooms. This deficient practiced placed R38 at risk for impaired ability to achieve and/or maintain her highest practicable level of physical and emotional well-being. (Refer to F740) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities for physician ordered hold parameter for R19's and R26's hypertensive medication (class of medication used to treat high blood pressure). This deficient practice placed these residents at risk for unnecessary medication administration and possible harmful side effects. (Refer to F756) Based on observation, record review, and interviews, the facility failed to ensure the staff followed the physician ordered hold parameter for R19's and R26's hypertensive medication (class of medication used to treat high blood pressure). The facility further failed to follow a physician order to obtain lab work ordered for R42. This deficient practice placed these residents at risk for unnecessary medication administration and possible harmful side effects. (Refer to F757) Based on observations, record review, and interviews, the facility failed to ensure R26 had an appropriate diagnosis for antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment testing] and other mental emotional conditions) medication usage. This deficient practice had the risk for unnecessary medication use and unwarranted physical complications. (Refer to F758) Based on observation, record review, and interviews, the facility failed to provide R42, who required thickened liquids, with the correct consistency as ordered. This deficient practice placed R42 at increased risk for adverse side effects of aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit) and dehydration. (Refer to F807) Based on observations, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to clean supply storage, respiratory equipment, and waste management. This deficient practice placed the residents at risk for complications related to infectious diseases. (Refer to F880) On 02/16/23 at 02:53 PM Administrative Staff B stated the QAA committee met monthly. Administrative Staff B stated the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Social Services, Minimum Data Set coordinator, Therapy Director, Infection Preventionist, and Director of Operations attend monthly. Administrative Staff B stated any issues that arise in morning meetings and at weekly risk meetings are discussed. The facility failed to maintain an effective QAA program to identify quality issues and develop PIPs. This deficient practice placed the residents at risk for a decrease in quality of care and treatment and quality of life.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 48 residents. Based on observations, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to clean linen storage, removal of trash, and prevention of cross-contamination. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings Included: - On 02/13/23 at 07:40 AM an initial walkthrough of the dementia unit revealed the unit's ice bucket scoop left in the ice without a barrier to prevent contamination from the handle. On 02/13/23 at 08:11 AM used bed linens and a hospital gown were on the floor from of room [ROOM NUMBER], from a resident that discharged the previous evening. On 02/14/23 at 07:27 AM observation revealed a roller cart with clean linen remained uncovered on the dementia unit, in the secondary dining room. On 02/14/23 at 08:45 AM observation revealed the dementia unit's ice bucket scoop was left in the ice, without a barrier to prevent contamination from the handle. On 02/16/23 at 09:47 AM a trash bag of soiled linen with urine-soaked sheets remained on the floor outside of the shower room. On 02/14/23 at 08:05 AM Certified Medication Aide (CMA) S stated all clean linen must covered and stored cleanly and the ice scoop should not be left in the ice bucket due to contamination. On 02/16/23 at 11:45 AM, Licensed Nurse (LN) H stated trash and bags should never be placed on the floor. She stated soiled linen should be transported directly to the soiled linen room, and clean linen and supplies should be stored in a clean closet or covered cart. On 02/16/23 at 12:11 PM, LN G stated staff have been trained and instructed not to place soiled laundry on the floor. He stated the linen should be placed in covered containers and transported to the soiled linen room and staff should have used a barrier with the ice scoop on the dementia unit. He stated the facility holds in-service training on infection control at least quarterly to refresh all staff on practices and policy. A review of the facility's Laundry and Linen policy revised 01/2014 noted all soiled linen must be placed in a covered hamper or stored to prevent moisture and contamination. The policy indicated all clean linen must be stored separate from soiled and covered to prevent environmental contamination. The facility failed to ensure proper infection control standards were followed related to clean linen storage, removal of trash, and prevention of cross-contamination. This deficient practice placed the residents at risk for complications related to infectious diseases.