STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41120 The facility census totaled 86 residents with four residents reviewed for falls and eight residents total in the facility that required the use of a full mechanical lift with sling. Based on observation, interview, and record review the facility failed to report an allegation of neglect to the State Agency per regulation when staff did not provide the supervision necessary to facilitate a safe transfer and used an incorrect sling for transfer from the bed to the wheelchair with the full mechanical lift, causing Resident (R) 12 to fall from the lift to the floor, striking her head on the lift, and she required an emergency room transfer for evaluation of these injuries. Findings included: - R12's pertinent diagnoses from 07/06/21 Physician's Order Summary revealed cerebrovascular disease (a group of conditions that affect the circulation of blood to the brain, causing limited or no blood flow to affected areas of the brain), hemiplegia (paralysis of one side of the body) affecting right dominant side, and multiple sclerosis (MS, progressive disease of the nerve fibers of the brain and spinal cord). The 11/06/20 Annual Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. The resident required extensive assistance of two staff for transfers, noted impairment to the upper and lower extremities (limbs) on one side of her body, and used a wheelchair for mobility. R12 experienced no falls since the last assessment. The 08/03/21 Quarterly MDS revealed the resident had a BIMS of 11, indicating moderate cognitive impairment. The resident was totally dependent on two staff for transfers, noted impairment to her upper and lower extremities on one side of her body, and used a wheelchair for mobility. The MDS noted R12 had no falls since the last assessment and noted she received daily anticoagulant (blood thinner) medication in the seven-day review period. The 03/01/16 Activities of Daily Living (ADL) Care Plan revealed a revision dated 08/09/19 noting the resident required two staff assistance with a full mechanical lift for transfers. The care plan lacked direction for the required sling type. The 03/01/16 Fall Care Plan revealed a revision dated of 06/08/21 that stated R12 was at risk for falls due to the resident needing a full mechanical lift with two staff assistance. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 06/07/21 at 02:00 PM Occurrence Report fall investigation revealed the resident fell at 01:52 PM and stated her head hurt. The nurse noted a large raised area to the occipital lobe [back of the head]. Staff notified the physician and the resident was sent to the emergency room (ER). Witness statement for CNA M noted R12 had been laid down [in bed], her family arrived, and the staff had to switch slings because we gave the resident a shower. CNA D lifted the resident off the bed, while CNA M walked around the bed, and R12 somersaulted out of the shower sling and hit her left shoulder and head on lift. Review of 06/07/21 at 02:24 PM Situation, Background, Assessment and Recommendation (SBAR) Communication Form and Progress Note revealed R12 fell from the full mechanical lift sling during transfer, and sustained a large raised area to her occipital (back of the head) lobe from hitting her head on the base of the mechanical lift. The resident stated, my head hurts. The staff notified the physician and sent R12 to the emergency room (ER) for evaluation. Review of the facility information regarding the 06/07/21 incident with R12, lacked evidence the facility reported 06/07/21 fall from the lift to the state reporting agency. Interview with CNA D on 08/17/21 at 04:55 PM revealed she and CNA M were getting R12 up to her wheelchair. The resident did not cross her arms and held onto the sides of the net shower sling for the transfer from her bed to wheelchair because we needed to hurry because her family was here, that is the only sling we had, and we wanted to be quick She then stated, everything was tied right, all the hooks, and the resident slipped out of the top of the sling. It happened so fast; she did not know how it happened. The CNAs received regular evaluations every year on sling/lift use. She thought the shower slings were too slippery and did not know if the sling was the right size, but did state, we have used this sling for [R12] before for showers, but the CNAs do not like to use the shower slings unless the resident was being placed in the shower chair, not for normal transfers. Interview with CNA E on 08/18/21 at 07:53 AM revealed staff were not to use the blue net shower slings for R12 for regular transfers because of her fall from the lift. She stated if a sling was not placed high enough above the shoulders with the shower sling, a resident could slide out the bottom or top, and that was why staff do not use them for regular transfers. R12 did tend to hang onto the sling for support, but that would not have caused her to slide out. The shower slings could be slippery and were just not as safe as the crisscross regular ones. When CNAs would get a resident up with the full mechanical lift and sling, one staff should use the lift controls and one staff should hold the sling in the correct position to stabilize the sling. Interview with Licensed Nurse (LN) F on 08/18/21 at 10:32 AM revealed the blue net shower slings were not to be used for regular transfers, and the facility had about six to seven full mechanical lifts that needed regular slings. When staff transferred residents with the full mechanical lift, two staff assist, with one using the controls, and the other guiding the sling and ensuring correct placement of the sling. The CNAs knew to go to the maintenance staff to let them know of any equipment issues. She had not heard anything about a wobbly lift. Interview with Administrative Staff A 08/18/21 at 05:00 PM verified he did not report the 06/07/21 incident involving R12 because everything was done right, and the staff did what they were supposed to do. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of revised 11/2018 Abuse, Prevention and Prohibition Policy revealed the employee or agent of the facility shall not neglect a resident. The facility Administrator, employee, or agent who is made aware of any allegation of neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. If the event that cause the allegation do not involve abuse and do not result in serious bodily injury, these will be reported to the administrator immediately and to State Survey Agency not later than 24 hours. The definition of neglect means failure to provide services necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility failed to report an allegation of neglect to the State Agency when staff did not provide the supervision necessary to facilitate a safe transfer and used an incorrect sling for transfer for transfer from bed to wheelchair with the full mechanical lift, causing R12 to fall from the lift to the floor, striking her head on the lift and she required an emergency room transfer for evaluation.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41120 The facility census totaled 86 residents with 12 residents included in the sample, and four reviewed for falls. Based on observation, interview, and record review the facility failed to ensure an environment free of accident hazards when facility staff utilized a full mechanical lift, with known signs of instability to transfer residents. On 06/07/21, Resident (R) 12 fell out of the top of a shower sling (incorrect sling type) from the full mechanical lift used to transfer her from her bed to her wheelchair and required an emergency room transfer for evaluation of a large bump to the back of her head from hitting it on the lift. The facility further failed to identify the causal factor of the fall on 06/07/21 when the investigation did not identify the staff utilized the unstable lift, used the incorrect sling, and both direct care staff did not provide the supervision necessary to facilitate a safe transfer. These failures placed R12, and seven other residents who used full mechanical lift for transfers, in immediate jeopardy. The facility also failed to complete a fall investigation, determine the cause of the fall, and revise the care plan with fall prevention strategies for a non-injury fall that R11 experienced on 08/03/21. Findings included: - R12's pertinent diagnoses from 07/06/21 Physician's Order Summary revealed cerebrovascular disease (a group of conditions that affect the circulation of blood to the brain, causing limited or no blood flow to affected areas of the brain), hemiplegia (paralysis of one side of the body) affecting right dominant side, and multiple sclerosis (MS, progressive disease of the nerve fibers of the brain and spinal cord). The 11/06/20 Annual Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. The resident required extensive assistance of two staff for transfers, noted impairment to the upper and lower extremities (limbs) on one side of her body, and used a wheelchair for mobility. R12 experienced no falls since the last assessment. The 11/06/20 Activities of Daily Living (ADL) Care Area Assessment (CAA) revealed staff provided physical assistance and cues for ADLs. The 11/06/20 Fall CAA revealed R12 would be free from falls and staff anticipated her needs. The 08/03/21 Quarterly MDS revealed the resident had a BIMS of 11, indicating moderate cognitive impairment. The resident was totally dependent on two staff for transfers, noted impairment to her upper and lower extremities on one side of her body, and used a wheelchair for mobility. The MDS noted R12 had no falls since the last assessment and noted she received daily anticoagulant (blood thinner) medication in the seven-day review period. R12's 03/01/16 Care Plan revealed a revision on 04/26/17 that noted she had a history of stroke/cerebrovascular accident (CVA, sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 03/01/16 Activities of Daily Living (ADL) Care Plan revealed a revision dated 08/09/19 noting the resident required two staff assistance with a full mechanical lift for transfers. The care plan lacked direction for the required sling type. The 03/01/16 Fall Care Plan revealed a revision dated of 06/08/21 that stated R12 was at risk for falls due to the resident needing a full mechanical lift with two staff assistance. The 06/07/21 at 02:14 PM Situation, Background, Assessment and Recommendation (SBAR) Note revealed Certified Nurse Aide (CNA) D and CNA M laid the resident down after her shower and then her family came to visit. CNA D raised the resident off of the bed with the mechanical lift while CNA M walked around the bed, and then the resident fell from the top of the sling, hitting her left shoulder and her head on lift. Imaging at the hospital revealed no head injuries. The SBAR Note documented the resident's actions of grabbing the sling instead of folding her arms across her body as the root cause of the fall. The SBAR Note documented the immediate intervention was to re-educate and remind the resident to fold her arms across her body during lift transfers. The 06/07/21 at 02:00 PM Occurrence Report fall investigation revealed the resident fell at 01:52 PM and stated her head hurt. The nurse noted a large raised area to the occipital lobe [back of the head]. Staff notified the physician and the resident was sent to the emergency room (ER). Witness statement for CNA M noted R12 had been laid down [in bed], her family arrived, and the staff had to switch slings because we gave the resident a shower. CNA D lifted the resident off the bed, while CNA M walked around the bed, and R12 somersaulted out of the shower sling and hit her left shoulder and head on lift. Review of 06/07/21 at 02:24 PM SBAR Communication Form and Progress Note revealed R12 fell from the full mechanical lift sling during transfer. She had a large raised area to her occipital (back of the head) lobe from hitting her head on the base of the mechanical lift. The resident stated, my head hurts. The staff notified the physician and sent R12 to the ER for evaluation. The 06/08/21 at 09:18 AM Follow-up Report for Occurrence fall investigation revealed staff transferred the resident from her bed to the wheelchair when R12 fell out of the sling to the floor hitting her shoulder and head on the base of the lift. The physician gave orders to send the resident to the ER due to the height of the fall and hitting her head. The fall investigation identified the resident's actions of grabbing the sling instead of folding her arms across her body as the root cause of the fall with the immediate intervention noted to re-educate and remind the resident to fold arms across her body during lift transfers. The 06/07/21 Hospital Documentation Summary revealed the resident experienced a bump to the back of her head and a headache and imaging of her head and spine showed no abnormalities. The 08/01/20 to 08/16/21 Work History Report for mechanical lifts revealed maintenance staff inspected all lifts on 08/31/20, 10/16/20, 12/03/20, 02/10/21, 04/08/21, 06/08/21, and 08/16/21 with no abnormalities noted. Observation of R12 on 08/17/21 at 03:50 PM revealed the resident seated in her wheelchair in the common area near the front of the building. Observation revealed a blue net shower sling placed under the resident between the resident and the wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 08/18/21 at 07:50 AM revealed CNA N and CNA E used a regular grey sling to transfer R12. CNA E held the sling secure and ensured the slings correct placement while on the right side of the resident. CNA N worked the lift control with one hand and held the sling secure with the other hand on the left side of the resident while lifting/transferring in the mechanical lift. Observation revealed the lift arm noted to be wobbling from side to side, while transferring the resident. Interview with R12 on 08/17/21 at 03:52 PM revealed the day she fell out of the mechanical full lift, she had just taken a shower, the CNAs helped her to dress, and then put her to bed. Her family came for a visit, so the CNAs started to lift her up in the sling, she fell and got a big bump on her head. She then stated, she fell about two to four feet to the floor. Interview with CNA C on 08/17/21 at 09:42 AM revealed she worked at the facility since the middle of 2021 and that the wobbly full mechanical lift has been that way since her first day. She reported the wobbly lift to Maintenance Staff G and H multiple times, and she did not tell the nurse because she just went straight to the maintenance staff with her concern. Interview with CNA D on 08/17/21 at 04:55 PM revealed she and CNA M were getting R12 up to her wheelchair. The resident did not cross her arms and held onto the sides of the net shower sling for the transfer from her bed to wheelchair because we needed to hurry because her family was here, that is the only sling we had, and we wanted to be quick She then stated, everything was tied right, all the hooks, and the resident slipped out of the top of the sling. It happened so fast, she did not know how it happened. The CNAs received regular evaluations every year on sling/lift use. She thought the shower slings were too slippery and did not know if the sling was the right size, but did state, we have used this sling for [R12] before for showers, but the CNAs do not like to use the shower slings unless the resident was being placed in the shower chair, not for normal transfers. Interview with CNA E on 08/18/21 at 07:53 AM revealed staff were not to use the blue net shower slings for R12 for regular transfers because of her fall from the lift. She stated if a sling was not placed high enough above the shoulders with the shower sling, a resident could slide out the bottom or top, and that was why staff do not use them for regular transfers. R12 did tend to hang onto the sling for support, but that would not have caused her to slide out. The shower slings could be slippery and were just not as safe as the crisscross regular ones. When CNAs would get a resident up with the full mechanical lift and sling, one staff should use the lift controls and one staff should hold the sling in the correct position to stabilize the sling. Interview with Licensed Nurse (LN) F on 08/18/21 at 10:32 AM revealed the blue net shower slings were not to be used for regular transfers, and the facility had about six to seven full mechanical lifts that needed regular slings. When staff transferred residents with the full mechanical lift, two staff assist, with one using the controls, and the other guiding the sling and ensuring correct placement of the sling. The CNAs knew to go to the maintenance staff to let them know of any equipment issues. She had not heard anything about a wobbly lift. Interview with LN I on 08/18/21 at 11:50 AM revealed no CNAs mentioned anything about a wobbly or unsafe lift to him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Maintenance staff G on 08/18/21 at 08:51 AM revealed he checked the mechanical lifts every other month for functionality, took off the wheels, cleaned them, and greased everything. When shown the lift that was wobbly he then stated, I was not told about this lift's condition and he removed the lift from the floor for maintenance. Interview with Maintenance Director H on 08/18/21 at 11:53 AM revealed today was the first he heard about a wobbly lift and no staff mentioned the lift before today. Maintenance checked the lifts on a weekly basis, but does not document the weekly checks, only every other month checks. Interview with Administrative Nurse B on 08/18/21 at 08:20 AM revealed he expected staff to use the blue net shower slings for resident showers, and the regular slings should be used to transfer the resident any other time. Interview with Administrative staff A on 08/18/21 at 05:00 PM revealed he could not find CNA M's mechanical lift competency as requested on 08/17/21. Review of 01/2017 Safe Lifting and Movement of Residents policy revealed staff responsible for direct resident care will be trained in the use of mechanical lifting devices. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. Staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order. Review of revised 09/17/19 Fall Policy revealed the facility shall ensure, following any falls, details of the fall will be recorded, and potential causal factors identified, investigated, and interventions will be implemented. The facility failed to ensure an environment free of accident hazards, when facility staff utilized a full mechanical lift, with known signs of instability, for R12's transfer from her bed to her wheelchair on 06/07/21 causing her to fall from the top of the shower sling from the full mechanical lift. She required an emergency room transfer for evaluation of a large bump to the back of her head from striking the lift. The facility further failed to identify the causal factor of the fall on 06/07/21 when the investigation did not identify the staff utilized the unstable lift, used the incorrect sling, and both direct care staff did not provide the supervision necessary to facilitate a safe transfer. These failures placed R12, and seven other residents who used full mechanical lift for transfers, in immediate jeopardy. On 08/18/21 at 04:15 PM, the Administrative staff A and the Administrative Nurse B were provided with the IJ template and notified of the failure to ensure staff utilized the correct sling, utilized a lift noted as wobbly, and the lack of identifying causal factors related to the fall from the top of the lift experienced by R12, placed R12 and the seven other residents who required full mechanical lift transfers in immediate jeopardy. The immediate jeopardy was determined to first exist on 06/07/21 at approximately 02:00 PM, when the facility staff did not provide the appropriate sling type or the appropriate assistance to R12 which caused a fall from the full mechanical lift, in which she hit her head and required emergency room evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility presented an acceptable plan for removal of the immediate jeopardy on 08/18/21 at 08:33 PM when the facility maintenance pulled the unsafe lift from the floor for maintenance which revealed a loose shoulder bolt on the mast of the lift that goes through the mast and holds the arm in place securely per Administrative Staff A interview. Maintenance completes every other month checks on lifts, and when needed. Re-education to staff was initiated on fall processes, competency on full mechanical lifts and slings, and they were educated on defective equipment, where to put it and who to notify for repairs. All staff will complete the training before they are allowed to work another shift. All topics would be reviewed at the daily clinic review, and the corporate nurse educator will review fall occurrence reports weekly. The fall and lift policies were reviewed, and QAPI will audit monthly. The survey team validated the immediate jeopardy was removed on 08/19/21 at 07:30 AM following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a E (pattern, with no actual harm) scope and severity following the removal of the immediate jeopardy. - R11's pertinent diagnoses from the Physician's Orders in the electronic medical record (EMR) dated 06/14/21 revealed: atrial fibrillation (a rapid, irregular heart beat) and muscle weakness. The 05/11/21 Admission Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of 11, indicating moderately impaired cognition. The resident required supervision and assistance of one staff for transfers, total dependence on one staff with toileting, and used a wheelchair for mobility. R1 was at risk for falls with none noted in the review period. The 05/11/21 Cognitive Loss Care Area Assessment (CAA) revealed R11 exhibited inattention, disorganized thinking, and difficulty focusing attention. The 05/11/21 Activities of Daily Living (ADL) CAA revealed R11 required supervision to total staff assistance for ADLs. He ambulated in his room and used a wheelchair for his main mode of locomotion. The 05/11/21 Fall CAA revealed R11 exhibited balance problems, was only able to stabilize with staff assistance, and had falls prior to entry into facility. The 07/22/21 Quarterly MDS revealed a BIMS score of 10 which indicated moderately impaired cognition. The resident required supervision and assistance of one staff with transfers, extensive assistance of one staff with toileting, and used a wheelchair and walker for mobility. He had one non-injury fall noted since the last assessment. Review of the 05/04/21 Fall Care Plan revealed R11 was a fall risk. A revision dated 07/06/21 revealed staff were to place assistive devices and personal items in reach when the resident was in his recliner with the call light in reach. He must not be left in the bathroom unattended and must have appropriate footwear or non-skid socks in place for ambulation. The care plan lacked a revision after the 08/03/21 fall. The 05/04/21 and 05/26/21 Fall Risk Data Collection assessments revealed R11 was at high risk for falls. Another Fall Risk Data Collection assessment completed on 06/14/21 noted the resident was at low risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An 08/03/21 at 04:22 PM Activity Note revealed R11 reported he fell in the bathroom a while ago and got himself up, stated he had a bruise on his knee, but was gone. Staff completed a skin assessment with no bruising noted. Staff notified Administrative Nurse B. Review of 08/03/21 at 06:53 PM Health Status Note revealed staff reported the fall to Administrative Nurse B who also assessed the resident with no abnormalities. The resident was able to perform full range of motion. Observation on 08/19/21 at 10:14 AM to 12:04 PM revealed R11 lying on bed with his head up, watching television with no visible bruising or distress with shoes in place. CNA P walked up and down the resident hallway and checked on the resident. He did not activate the call light during this observation. Interview with R11 on 08/17/21 at 04:00 PM revealed he fell out of his wheelchair and scratched his knee up the last time he fell . Interview with Certified Nurse Aide (CNA) O on 08/17/21 at 02:35 PM revealed she does not know of any falls for R11 other than the one when he first arrived at the facility. Interview with Licensed Nurse (LN) J on 08/19/21 at 02:59 PM revealed he was the nurse working on 08/03/21 when the resident said he fell . LN J stated, [R11] said he fell a couple times, but he checked [R11] over and did not see anything, so that is why he did not fill out a fall occurrence/investigation or Situation, Background, Assessment and Recommendation (SBAR) form/note. He also mentioned that he notified Administrative Nurse B. Interview with Administrative Nurse B on 08/19/21 at 01:34 PM revealed he was unaware of a fall on 08/03/21. R11 mentioned he bumped his knee on the cabinets in his room that day, but no one told him R11 fell . His expectation for resident falls were that the nurse should document the fall and any injuries, like the size/location of the injury/wound and document wound care as well. The facility's revised 09/17/19 Fall Policy revealed the facility shall ensure, following any falls, the facility staff completes an occurrence report. Details of the fall will be recorded, and potential causal factors identified, investigated and interventions will be implemented. The facility failed to complete a fall investigation, determine the cause of the fall, and revise the care plan with fall prevention strategies for a fall that R11 experienced on 08/03/21.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41120 The facility census totaled 86 residents. Based on observation, interview, and record review the facility failed to ensure resident (R) 9 had his suprapubic catheter (urinary bladder catheter inserted through the skin) replaced per the physician's orders, resulting in his catheter not being changed in five months. Findings included: - Review of R9's pertinent diagnoses from the Physician's Progress Notes dated 07/14/21 revealed obstructive uropathy (blocked urinary tract) with a suprapubic catheter. The 04/27/21 Annual Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of 14, indicating intact cognition and R9 had an indwelling catheter. Review of the 04/27/21 Cognitive Care Area Assessment (CAA) revealed R9 changed from subject to subject when having a conversation and did not always make safe rational decisions for himself. The 04/27/21 Urinary Incontinence and Indwelling Catheter CAA revealed R9 required a suprapubic catheter and staff should change the catheter when needed. The 07/13/21 Quarterly MDS revealed a BIMS of 14 and he had an indwelling catheter. The 05/23/18 Catheter Care Plan revised on 04/20/21 revealed the resident had a suprapubic catheter with physician orders for the catheter type/size and staff required to change the catheter as needed for blockage or dislodgement every 30 days. The 01/22/21 Physician Orders revealed R9 required an 18 French (Fr, diameter of catheter) catheter with 10 milliliter (mL) bulb (inflatable balloon that holds the catheter in place)., The 03/16/21 Physician Orders revealed staff were to change R9s catheter as needed for blockage/dislodgement. Review of 04/01/21 to 08/16/21 Treatment Administration Record (TAR) for the above order for catheter changes revealed there were no catheter changes documented. The 03/24/21 Urology Office/Clinic Notes revealed Return to clinic (RTC) 4 weeks for [until] catheter change. Observation on 08/18/21 at 10:44 AM revealed Licensed Nurse (LN) I in R9s room to provide catheter care. The suprapubic catheter tubing was mustard yellow near the insertion site, and brownish red approximately two inches away from insertion site down to the catheter bag. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with R9 on 08/18/21 at 10:23 AM revealed the nurses changed his catheter about every three to four weeks when he first got the catheter at the beginning of 2021, but staff have not changed his catheter in more than three months, maybe longer. Interview with LN I on 08/18/21 at 10:40 AM revealed R9's catheter looked old; the coloring of the tubing indicated that to him. He stated, I have checked with the provider and we are going to check on when it was last changed, because the TAR does not show that the catheter has been changed in months. Interview with Administrative Nurse B on 08/19/21 at 01:29 PM revealed the last documented catheter change that could be found was by the urologist office when he had his appointment on 03/24/21. The as needed catheter change order that he placed in the resident's chart was from the admission paperwork from the hospital, and he stated, he did not see the frequency of catheter change from the appointment on 03/24/21. He continued, there was the risk of infection without proper catheter changes. The catheter frequency of change order was not updated with frequency ordered by the urologist at the 03/24/21 appointment. Interview with Administrative staff A on 08/19/21 at 01:20 PM revealed the last documentation for R9's last catheter change was on 03/24/21 at the urologist appointment. When the facility called the urologist to schedule a follow-up appointment on 03/24/21, the urology office said the catheter could be changed here at the facility. Review of 01/2017 Catheter Care, Urinary policy revealed catheters will be changed per medical practitioner order. The policy lacked information on documentation of catheter changes, or catheter care. The facility failed to ensure R9 had his suprapubic catheter replaced per the physician's orders, resulting in his catheter not being changed in five months.