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	12/13/2022

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 37450 The facility had a census of 92 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to act promptly upon the concerns of the resident council group concerning issues of care and life in the facility. This placed the residents at risk of decreased quality of care and services. Findings included: - Review of the monthly Resident Council meeting recorded the following: On 12/28/21 the resident council minutes recorded 11 residents in attendance with concerns that hand towels and washcloths were not being passed to the residents and the bed linens not changed. On 01/27/22 the resident minute council minutes recorded 13 residents in attendance with concerns that hand towels and washcloths were not being passed out, beds were not made, and residents were not getting clean ice cups or ice. On 02/15/22 the resident council minutes recorded seven residents in attendance with concerns the residents were only getting ice water once a day or not at all, call lights were not getting answered and staff were reporting they were busy, residents were told the facility ran out of towels, and there was a time limit on showers. Resident also reported they were not getting shaved and/or nails cut. On 03/15/22 the resident council minutes recorded 11 residents in attendance with concerns the residents were not getting ice passed and had to get ice themselves, and snacks were not getting passed. On 04/29/22 the resident council minutes recorded 12 residents in attendance with concerns that snacks were not getting passed out and room meal trays were not being picked up. On 05/27/22 the resident council minutes recorded eight residents in attendance with concerns that day shift staff were not picking up room trays; there were comments the linen problem and snack pass had improved. On 06/24/22 the resident council meeting minutes recorded 17 residents in attendance, but the concern portion of the meeting was left blank. (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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/29/22 the resident council meeting minutes recorded six residents in attendance who verbalized concerns with ice not getting passed and running out of towels. On 08/26/22 the resident council meeting minutes recorded 15 residents in attendance with concerns from the new food committee regarding bland foods, no seasoning on the room tray cart and staff getting food before resident. Other concerns noted were residents' beds were not getting made, residents were not getting showers, there were no staff to give showers, and running out of towels. On 09/30/22 the resident council meeting minutes recorded 23 residents in attendance with concerns of day shift not offering meal choices, nurse aides not pulling curtains when doing cares, showers not getting done, and no condiments on room trays. On 10/28/22 the resident council meeting minutes recorded 14 residents in attendance with concerns of smoking residents going outside by themselves and wanting bacon for breakfast. On 11/28/22 the resident council meeting minutes recorded eight residents in attendance and documented the residents feel like their concerns are not being taken care of. They feel there is no point in coming to resident council because it is the same problems. On 12/12/22 at 02:00 PM state agency personnel met with seven council residents. Collectively the residents did not feel their concerns are heard related to repeat unresolved concerns. On 12/12/22 at 03:01 PM Activity Staff Z reported the resident council concerns were passed onto the social service staff and social service staff takes the concerns to the administrator. On 12/13/22 at 09:49 AM Administrative Staff A reported the facility had ordered more towels and other lines in the past two months and the Director of Nursing (DON) developed a Performance Improvement Plan (PIP) for bathing, and the facility had added a bath aide to the schedule. On 12/13/22 at 01:50 PM, Administrative Nurse D reported she had not been invited to the resident council meeting and could not attend unless she was invited to address issues concerning resident council. The facility Resident Council policy, dated 02/2016, documented a designated staff member of the facility is to assist and help coordinate the Council meetings. All employees' affiliates or visitors may only attend council meeting after obtaining approval from the Resident council before attending. The resident council shall meet at least one time per month with the facility staff who shall aid the council in preparing and disseminating a report of each meeting (minutes) to all residents, the administrator, and the facility staff. The council may communicate to the administrator the opinions and concerns of the residents. The council shall review procedures for resident rights and facility responsibilities, and the council make recommendations for changes or additions which will strengthen the facilities policies and procedures as they affect resident rights. Any concerns identified in the resident council will be addressed. The facility failed to an act promptly upon the concerns of the resident council groups concerning issues of care and life in the facility, which placed the residents who resided in the facility at risk for lack of resident quality of life.

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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. 25671 The facility had a census of 92 residents. Thirteen residents resided on the secured female memory care unit. Based on observation, record review, and interview the facility failed to provide housekeeping services to maintain a sanitary and homelike environment for the 13 residents who reside on the memory care unit. This placed the residents at risk for reduced quality of life. Findings included: - On 12/07/22 at 08:29 AM, observation revealed an intense urine odor permeated the seven resident rooms, hall, and dining room on the female memory care unit. Continued observation revealed five residents eating breakfast in the dining room, and the urine odor completely obscured the food aroma. On 12/07/22 at 11:49 AM, observation revealed an intense urine odor continued to permeate the seven resident rooms, hall, and dining room on the female memory care unit. Observation revealed 12 residents eating lunch in the dining room, and the urine odor completely obscured the food aroma. On 12/07/22 at 11:49 AM, Certified Nurse Aide (CNA) Q stated she was aware of the urine odor, not sure what caused the urine odor, and had not contacted housekeeping services to address the urine odor. On 12/07/22 at 12:04 PM, Licensed Nurse (LN) I stated the memory care unit had a strong urine odor today, and she would report the urine odor to housekeeping services. On 12/13/22 at 09:51 AM, Administrative Nurse D stated staff should address the urine odor on the memory care unit, and ensure a clean, odor-free environment for the residents. The facility failed to provide housekeeping services to maintain a sanitary and homelike environment for the 13 residents who reside on the memory care unit, placing the residents at risk for reduced quality of life.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 92 residents. The sample included 22 residents, with five reviewed for abuse. Based on observation, record review, and interview, the facility failed to prevent an incident of neglect for Resident (R)36, when staff willfully refused to provide R36 the required level of toileting assistance. The facility furtehr failed to prevent resident to resident abuse by Resident (R)194, who had multiple resident to resident altercations.This deficient practice placed the residents at risk for injury and impaired physical and psychosocial well-being. Findings Included: - R36's Electronic Medical Record (EMR) documented diagnoses including a fractured femur (thigh bone) and dementia (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired decision-making skill. The MDS documented R36 had delusions (belief or altered reality that is persistently held despite evidence or agreement to the contrary), and no behaviors. The MDS documented R36 required limited assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADL) and had a fall with fracture and surgery prior to admission. The MDS documented R36 had no toileting program and was frequently incontinent of bowel and bladder. The Dementia Care Area Assessment (CAA), dated 11/02/22, documented R36 was alert with impaired memory function, poor decision skills and safety awareness. The Bowel and Bladder Incontinence Care Plan, dated 10/27/22, stated the resident used large disposable briefs and directed staff to encourage and assist R36 with toileting or incontinent care upon rising, before and after meals, at bedtime, twice during night with rounds, and as needed or requested. The ADL Care Plan for toilet use stated R36 was totally dependent on staff with assistance of one to two staff for toilet use. The Fall Care Plan, dated 11/06/22, directed staff to assist the resident with toileting and incontinent care with use of briefs for prevention of moisture to floor for safety. The Progress Note, dated 10/30/22, documented R36 was alert and had both short- and long-term memory problems, did not have delusions, and decision making was impaired. The Progress Note, dated 11/1/22 at 10:32 AM, documented R36 had the following behavioral issues: yelling. The Progress Note, dated 11/15/22 at 09:07 AM, documented R36 had the following behavioral issues: yelling help instead of using her call light. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/08/22 at 08:21 AM, observation revealed R36 sat in her wheelchair in the doorway of her room. R36 told Certified Nurse Aide (CNA) QQ , who was delivering meals in the hall, she (R36) had to go to the bathroom bad. CNA QQ told R36 that because R36 had a brief on to just go ahead and go. R36 replied she had to go bad. When R36 saw Certified Medication Aide (CMA) PP in the hall, she yelled help and CMA PP assisted the resident with incontinence care. On 12/08/22 at 09:55 AM, Social Services X stated CMA PP had reported the exchange between CNA QQ and R36. Social Services X stated she educated CNA QQ regarding resident rights and abuse. On 12/08/22 at 11:19 AM, Administrative Nurse D stated she suspended CNA QQ and reported the incident to the state agency. The facility's Abuse policy, dated 10/2022, documented the facility prohibited mistreatment, neglect or abuse of residents. This also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. The facility failed to prevent neglect of R36 when she requested assistance to the bathroom and CNA QQ told her to just go in your brief. This deficient practice placed R36 at risk of impaired rights, impaired dignity, and lack of assistance for her needs. 32360 - The Electronic Medical Record (EMR) for R194 documented diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (a feeling of worry, nervousness, or unease). The Admission Minimum Data Set (MDS), dated [DATE], documented R194 had moderately impaired cognition and was dependent upon two staff for toileting, extensive assistance of two staff for dressing, supervision and set-up assistance for ambulation. R194 was independent with set-up assistance for bed mobility and transfers. The assessment further documented R194 had no behaviors and received an antipsychotic (medication used to manage psychotic disorders) and antidepressant (a medication used to treat depression and anxiety). R194's Significant Change MDS, dated [DATE], documented R194 had severely impaired cognition and was dependent upon two staff for toileting, bathing and extensive assistance of two staff for bed mobility, transfers, dressing, and supervision and set-up assistance for ambulation. The MDS further documented R194 had inattention, physical behaviors directed towards others, other behaviors, rejected care, and wandered four to six days. The MDS documented R194 received antipsychotic, antidepressant, antianxiety (medication used to treat anxiety), and opioid (narcotic used to treat pain) medication during the look back period. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan, dated 11/29/22, initiated on 04/22/22, documented R194 was resitive to cares and could be physically aggressive towards staff and other residents. The care plan directed staff to administer antipsychotic medications as ordered, monitor for side effects and effectiveness, obtain behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes, contact the physician as needed, and use the facility behavior monitoring protocols. The Nurse's Note, dated 07/18/22 at 09:06 AM, documented R194 struck R64 which caused R64 to fall to the ground hitting the back of his head. The note further documented R64 sustained a bump to the back of his head, and he was send to the emergency room for evaluation. The Nurse's Note, dated 07/18/22 at 11:03 AM, documented R194 assaulted R54 in the dining room, shoved a dining room table into R54's abdomen and tried to push him down. The note further documented staff separated the residents and assessed R54 for injury. The note further document R194 was sent to a behavioral hospital for evaluation and treatment. The Nurse's Note, dated 10/14/22 at 03:23 PM, documented R194 pushed an unidentified resident which caused the resident to fall to the floor. The note further documented the unidentified resident complained of back pain. The note documented staff contacted the physician. The EMR documented R194 passed away on 11/29/22. On 12/13/22 at 09:40 AM, Certified Medication Aide (CMA) R stated R194 was very aggressive, destructive and hard to redirect. CMA R further stated R194 had a lot of resident to resident altercations and staff had to separate him from other residents. CMA R stated when there were altercations, she called the nurse to assess. On 12/13/22 at 11:30 AM, Licensed Nurse (LN) H stated R194 would get angry and tried to take food from other residents and that would start a problem, LN H further stated she wrote in progress notes when there were altercations and notified the doctor and administration. On 12/13/22 at 01:01 PM, Administrative Nurse D stated she recently began to have the responsibility of completing abuse investigations and reporting. Administrative Nurse D further stated when the residents had any type of resident to resident altercations, she completed a report and notified the state agency when needed. The facility's Abuse Prevention and Prohibition policy, dated October 2022, documented, each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility failed to prevent incidents of resident to resident abuse by R194, which placed the residents at risk for injury and ongoing abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 92 residents. The sample included 22 residents. Based on record review and interview, the facility failed to report incidents of resident-to-resident abuse involving Resident (R) 194 to the state agency as required. The placed the residents at risk for ongoing injury and unidentified abuse or mistreatment. Findings Included: - The Electronic Medical Record (EMR) for R194 documented diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (a feeling of worry, nervousness, or unease). The Admission Minimum Data Set (MDS), dated [DATE], documented R194 had moderately impaired cognition and was dependent upon two staff for toileting, extensive assistance of two staff for dressing, supervision and set-up assistance for ambulation. R194 was independent with set-up assistance for bed mobility and transfers. The assessment further documented R194 had no behaviors and received an antipsychotic (medication used to manage psychotic disorders) and antidepressant (a medication used to treat depression and anxiety). R194's Significant Change MDS, dated [DATE], documented R194 had severely impaired cognition and was dependent upon two staff for toileting, bathing and extensive assistance of two staff for bed mobility, transfers, dressing, and supervision and set-up assistance for ambulation. The MDS further documented R194 had inattention, physical behaviors directed towards others, other behaviors, rejected care, and wandered four to six days. The MDS documented R194 received antipsychotic, antidepressant, antianxiety (medication used to treat anxiety), and opioid (narcotic used to treat pain) medication during the look back period. The Care Plan, dated 11/29/22, initiated on 04/22/22, documented R194 was resistive to cares and could be physically aggressive towards staff and other residents. The care plan directed staff to administer antipsychotic medications as ordered, monitor for side effects and effectiveness, obtain behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes, contact the physician as needed, and use the facility behavior monitoring protocols. The Nurse's Note, dated 07/18/22 at 11:03 AM, documented R194 assaulted R54 in the dining room, shoved a dining room table into R54's abdomen and tried to push him down. The note further documented staff separated the residents and assessed R54 for injury. The note further document R194 was sent to a behavioral hospital for evaluation and treatment. This incident of resident to resident abuse was not reported to the state agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note, dated 10/14/22 at 03:23 PM, documented R194 pushed an unidentified resident which caused the resident to fall to the floor. The note further documented the unidentified resident complained of back pain. The note documented staff contacted the physician. This incident of resident to resident abuse was not reported to the state agency. The EMR documented R194 passed away on 11/29/22. On 12/13/22 at 09:40 AM, Certified Medication Aide (CMA) R stated R194 was very aggressive, destructive and [NAME] to redirect. CMA R further stated R194 had a lot of resident-to-resident altercations and staff had to separate him from other residents. CMA R stated when there were altercations, she called the nurse to assess. On 12/13/22 at 11:30 AM, Licensed Nurse (LN) H stated R194 would get angry and tried to take food from other residents and that would start a problem, LN H further stated she wrote in progress notes when there were altercations and notified the doctor and administration. On 12/13/22 at 01:01 PM, Administrative Nurse D stated she recently began to have the responsibility of completing abuse investigations and reporting. Administrative Nurse D further stated when the residents had any type of resident-to-resident altercations, she completed a report and notified the state agency when needed. Administrative Nurse D verified she had not completed an investigation for the two incidents or reported the incidents to the state agency as required. The facility's Abuse Prevention and Prohibition policy, dated October 2022, documented the facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. Such reports may also be made to the local law enforcement agency in the same manner. The facility failed to report to the state agency as required incidents of resident-to-resident abuse involving R194. This placed the residents at risk for ongoing injury and abuse or mistreatment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 92 residents. The sample included 22 residents. Based on record review and interview, the facility failed to investigate incidents of resident-to-resident abuse involving Resident (R) 194. This placed the residents at risk for unidentified and ongoing abuse or mistreatment. Findings included: - The Electronic Medical Record (EMR) for R194 documented diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (a feeling of worry, nervousness, or unease). The Admission Minimum Data Set (MDS), dated [DATE], documented R194 had moderately impaired cognition and was dependent upon two staff for toileting, extensive assistance of two staff for dressing, supervision and set-up assistance for ambulation. R194 was independent with set-up assistance for bed mobility and transfers. The assessment further documented R194 had no behaviors and received an antipsychotic (medication used to manage psychotic disorders) and antidepressant (a medication used to treat depression and anxiety). R194's Significant Change MDS, dated [DATE], documented R194 had severely impaired cognition and was dependent upon two staff for toileting, bathing and extensive assistance of two staff for bed mobility, transfers, dressing, and supervision and set-up assistance for ambulation. The MDS further documented R194 had inattention, physical behaviors directed towards others, other behaviors, rejected care, and wandered four to six days. The MDS documented R194 received antipsychotic, antidepressant, antianxiety (medication used to treat anxiety), and opioid (narcotic used to treat pain) medication during the look back period. The Care Plan, dated 11/29/22, initiated on 04/22/22, documented R194 was resistive to cares and could be physically aggressive towards staff and other residents. The care plan directed staff to administer antipsychotic medications as ordered, monitor for side effects and effectiveness, obtain behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes, contact the physician as needed, and use the facility behavior monitoring protocols. The Nurse's Note, dated 07/18/22 at 11:03 AM, documented R194 assaulted R54 in the dining room, shoved a dining room table into R54's abdomen and tried to push him down. The note further documented staff separated the residents and assessed R54 for injury. The note further document R194 was sent to a behavioral hospital for evaluation and treatment. The Nurse's Note, dated 10/14/22 at 03:23 PM, documented R194 pushed an unidentified resident which caused the resident to fall to the floor. The note further documented the unidentified resident complained of back pain. The note documented staff contacted the physician. The EMR documented R194 passed away on 11/29/22. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/22 at 09:40 AM, Certified Medication Aide (CMA) R stated R194 was very aggressive, destructive and [NAME] to redirect. CMA R further stated R194 had a lot of resident-to-resident altercations and staff had to separate him from other residents. CMA R stated when there were altercations, she called the nurse to assess. On 12/13/22 at 11:30 AM, Licensed Nurse (LN) H stated R194 would get angry and tried to take food from other residents and that would start a problem, LN H further stated she wrote in progress notes when there were altercations and notified the doctor and administration. On 12/13/22 at 01:01 PM, Administrative Nurse D stated she recently began to have the responsibility of completing abuse investigations and reporting. Administrative Nurse D further stated when the residents had any type of resident-to-resident altercations, she completed a report and notified the state agency when needed. Administrative Nurse D verified she had not completed an investigation for the two incidents. The facility's Abuse Prevention and Prohibition policy, dated October 2022, documented resident abuse must be reported immediately to the Administrator. The facility Administrator would ensure a thorough investigation of alleged violations of individual rights and document appropriate action. While a facility investigation is under way, steps will be taken to prevent further abuse. The facility failed to investigate incidents of resident-to-resident abuse which placed the residents at risk for unidentified and ongoing abuse and mistreatment.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 92 residents. The sample included 22 residents with two reviewed for hospitalization . Based on observation, interview, and record review the facility failed to provide a bed hold notice to Resident (R)51, upon admission to the hospital twice. This deficient practice placed R51 at risk impaired rights to return to her original facility room upon return from the hospital. Findings included: - R51's Electronic Medical Record (EMR) documented diagnoses of pneumonia (severe inflammation of the lungs in which the alveoli (tiny air sacs) are filled with fluid), chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs), respiratory failure with hypoxia (low levels of oxygen in your body tissues), aspiration pneumonia (when food or liquid is breathed into the airways or lungs, instead of being swallowed), and a pulmonary abscess (pus-filled cavity in the lung surrounded by inflamed tissue and caused by an infection). The Significant Change Minimum Data Set (MDS), dated [DATE], documented intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS documented R51 required supervision for eating, hygiene, transfers, toileting, and limited assistance of one staff for bed mobility, walking, and dressing. The MDS documented R51 had shortness of breath with exertion, received antibiotics and oxygen therapy. The ADL Care Area Assessment (CAA), dated 11/10/22, documented R51 was recently readmitted to the facility from the hospital following treatment for sepsis (severe infection) and pneumonia. The Respiratory Care Plan, dated 11/15/22, lacked direction related to use of oxygen therapy. The Progress Note, dated 10/22/22 at 08:56 PM, documented R51 was transferred via ambulance to the hospital for a change in condition, abnormal vital signs, coarseness and crackles in lungs, chills, and a low oxygen saturation The Progress Note, dated 10/26/22, documented R51 returned to the facility. The Progress Note, dated 10/31/22 at 09:59 AM, documented R51's family requested staff to send R51 to the emergency room (ER). The EMR documented R51 returned to the facility from the hospital on 11/03/22. The clinical record lacked evidence a bed hold was issued to the resident and/or representative for either hospital admission. On 12/12/22 at 11:40 AM, observation revealed R51 stood by her wheelchair and her oxygen was hooked up to the tank on her wheelchair. The oxygen concentrator by her bed had no filter and had lint on the intake holes. (continued on next page)

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	175274	A. Building B. Wing	12/13/2022

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/22 at 01:25 PM, Social Service X verified she did not provide a bed hold notices when R51 went to the hospital. Upon request the facility did not provide a policy regarding bed hold. The facility failed to provide a bed hold notice to R51, upon admission to the hospital, twice placing R51 at risk for impaired rights to return to her original facility room upon return from the hospital.

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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** 26768 The facility had a census of 92 residents. The sample included 22 residents. Based on interview and record review the facility failed to develop a baseline care plan for Resident (R)293's immediate health and safety needs, including dietary, activities of daily living (ADL) assistance, communication barriers, and respiratory. This deficient practice placed R293 at risk for inadequate care and services related to her health and safety. Findings included: - R293's Electronic Medical Record (EMR) documented diagnoses of acute on chronic combined congestive heart failure (condition in which the heart has trouble pumping blood through the body), atrial fibrillation (type of irregular heartbeat), chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems), diabetes mellitus (a group of diseases that affect how the body uses blood sugar (glucose), and hypertension (high blood pressure). The Admission Minimum Data Set (MDS), dated [DATE], lacked information for the Brief Interview for Mental Status (BIMS) score. The MDS documented R293 was independent for bed mobility, eating, toileting, required supervision for hygiene, transfers, walking, locomotion, and limited assistance of one staff for dressing and bathing. The MDS documented R293 had frequent mild pain, shortness of breath with exertion or lying flat, less than six months prognosis and received hospice services. The MDS documented R293 weighed 125 pounds (lbs) had no teeth and received oxygen therapy. The Dental Care Area Assessment (CAA), dated 06/08/22, recorded R293 did not have natural teeth and wore full upper and lower dentures with no pain or abnormalities noted. Her weight was 125 lbs. She was able to eat a regular meal without difficulty. The Quarterly MDS, dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired decision-making skill. The MDS documented R293 was independent for bed mobility, eating, toileting, required supervision for hygiene, transfers, walking, locomotion, dressing and assistance for bathing. The MDS documented R293 had frequent mild pain, shortness of breath with exertion or lying flat, less than six months prognosis and received hospice services. The MDS documented R293 weighed 125 lbs. and received oxygen therapy. The Admission Assessment, dated 06/08/22, documented R293 had a language barrier and staff were unable to determine R293's activity likes or dislikes. The baseline Care Plan dated 06/01/22 documented R293 liked to get up in the morning at 08:00 AM and preferred to have her daughter involved in discussions of her care. The care plan lacked interventions which addressed R293's immediate care needs including ADL, hospice services, dietary or nutritional issues, and oxygen or respiratory concerns. The Activities of Daily Living (ADL) Care Plan, dated 09/07/22, documented the same as the initial care plan without any updates. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated 06/16/22 (two weeks after admission), documented the nurse spoke with the hospice nurse and hospice was bringing out a bed, oxygen concentrator, and wheelchair for R293 that afternoon. The Progress Note, dated 08/14/22, documented R293 spoke only Spanish and was observed to be in pain because she was pointing to her knee. The nurse called hospice for the medication, but the hospice nurse said the resident did not have an order with them and staff would have to call R293's doctor for the pain medication order. The hospice nurse recommended staff use Tylenol for the rest of the night until the next day. A Physician Order' dated 09/02/22, directed staff to provide oxygen at 2-5 liters, as needed, to keep oxygen level above 90 percent (%). The Progress Note, dated 10/02/22 at 11:07 AM, documented R293 was short of breath at rest, with diminished lung sounds, and an oxygen saturation level of 99 % on four liters of oxygen per minute. R293's family reported the resident was lightheaded and the nurse noted a pulse of 112 beats per minute (BPM). The Progress Note, dated 10/02/22 at 02:50 PM, documented R293 was transferred by ambulance to the hospital for respiratory distress with a pulse of 115 BPM. On 12/12/22 at 02:37 PM, Certified Nurse Aide (CNA) MM stated she translated Spanish to English a lot for R293 and her family who could understand, but not really speak, English. On 12/12/22 at 03:33 PM Administrative Nurse D verified R293's initial care plan lacked staff direction for assistance with ADLs, communication, hospice services, dietary, or oxygen treatment. Upon request the facility did not provide a policy for baseline care plans. The facility failed to develop a baseline care plan for R293's immediate health and safety needs, including dietary, ADL assistance, respiratory and communication, placing R293 at risk to receive inadequate care and services related to her health and safety.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25671 The facility had a census of 92 residents. The sample included 22 residents. Based on observation, interview and record review the facility failed to develop a comprehensive care plan for Resident (R) 72's diabetic and wound care needs. The facility further failed to develop a care plan for R293's health and safety needs, including dietary, activities of daily living (ADL) assistance, respiratory and communication. This deficient practice placed the residents at risk for inadequate care and services. Findings Included: - The Physician Order Sheet, dated 12/02/22, recorded R72 had diagnoses of diabetes mellitus (disease that affects the body ability to produce or respond to insulin and regulate blood sugar levels), (Parkinson's Disease (progressive disease of the central nervous system marked by tremors, muscular rigidity, and uncontrolled movements), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and muscle weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded R72 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) with rejection of care behaviors. The MDS recorded R72 required extensive staff assistance with bed mobility, transfers, used a wheelchair for mobility, had no pressure ulcers and had not received insulin injections. Review of R72's medical record on 12/13/22 lacked documentation of a care plan for pressure ulcers (wound to skin and underlying tissue from prolonged pressure on the area), diabetes, and insulin (medication used to control blood glucose levels) use. The Physician Order, dated 12/05/22, directed staff to check R72's blood sugar before meals and at bedtime, and call the physician per blood sugar parameters. The Physician's Order, dated 12/06/22, directed staff to administer Novolog insulin (fast acting insulin that helps lower mealtime blood sugars spikes) per a sliding scale (progressive increase in insulin related to blood sugar levels) to R72 and notify the physician if blood sugars were greater than 451 milligrams per decilitre (mg/dl). The Wound Evaluation Report, dated 12/08/22, recorded R72 developed a superficial pressure ulcer on the lower right buttock that measured 2.0 centimeters (cm) in diameter. The Wound Evaluation Report recorded R72 spent most of the day in his wheelchair, was incontinent of bowel and urine, and the resident frequently rejected incontinent cares. On 12/12/22 at 12:01 PM, observation revealed the resident sat in his wheelchair at the dining table eating lunch. On 12/12/22 at 02:59 PM, Licensed Nurse (LN) G stated R72 developed a new pressure ulcer recently and should have a care plan to address pressure ulcer prevention and healing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/22 at 08:03 AM, LN H stated R72 was diabetic, received scheduled blood sugar monitoring and insulin administration, and lacked a diabetic or insulin care plan. On 12/13/22 at 09:47 AM, Administrative Nurse D stated staff should have developed and implemented a comprehensive care plan to direct R72's diabetic and pressure ulcer cares and treatments. The facility's Comprehensive Care Plan Policy, dated February 2021, directed staff to complete a comprehensive care plan that was individualized, and met the resident's medical, nursing, and mental needs. The facility failed to develop and implement a diabetic and pressure ulcer care plan for R72, placing the resident at risk to not receive appropriate cares and treatments. 26768 - R293's Electronic Medical Record (EMR) documented diagnoses of acute on chronic combined congestive heart failure (condition in which the heart has trouble pumping blood through the body), atrial fibrillation (type of irregular heartbeat), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), diabetes mellitus (a group of diseases that affect how the body uses blood sugar (glucose), and hypertension (high blood pressure). The Admission Minimum Data Set (MDS), dated [DATE], lacked information for the Brief Interview for Mental Status (BIMS) score. The MDS documented R293 was independent for bed mobility, eating, toileting, required supervision for hygiene, transfers, walking, locomotion, and limited assistance of one staff for dressing and bathing. The MDS documented R293 had frequent mild pain, shortness of breath with exertion or lying flat, less than six months prognosis and received hospice services. The MDS documented R293 weighed 125 pounds (lbs) had no teeth and received oxygen therapy. The Dental Care Area Assessment (CAA), dated 06/08/22, recorded R293 did not have natural teeth and wore full upper and lower dentures with no pain or abnormalities noted. Her weight was 125 lbs. She was able to eat a regular meal without difficulty. The Quarterly MDS, dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired decision-making skill. The MDS documented R293 independent for bed mobility, eating, toileting, required supervision for hygiene, transfers, walking, locomotion, dressing and assistance for bathing. The MDS documented R293 had frequent mild pain, shortness of breath with exertion or lying flat, less than six months prognosis and received hospice services. The MDS documented R293 weighed 125 lbs. and received oxygen therapy. The Admission Assessment, dated 06/08/22, documented R293 had a language barrier and staff were unable to determine R293's activity likes or dislikes. The Care Plan upon admission, 06/01/22, documented R293 liked to get up in the morning at 08:00 AM and preferred to have her daughter involved in discussions of her care. The care plan lacked interventions for R293's immediate care including ADLs, hospice services, dietary or nutritional issues, and oxygen or respiratory concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information or direction was added to the care plan the entire time R293 was a resident of the facility. The Activities of Daily Living (ADL) Care Plan, dated 09/07/22, documented the same as the initial care plan without any revisions or updates. The Progress Note, dated 06/16/22 (two weeks after admission), documented the nurse spoke with the hospice nurse and hospice was bringing out a bed, oxygen concentrator, and wheelchair for R293 that afternoon. The Progress Note, dated 08/14/22, documented R293 spoke only Spanish and was observed to be in pain because she was pointing to her knee. The nurse called the hospice for the medication, but the hospice nurse said the resident did not have an order with them and staff would have to call R293's doctor for the pain medication order. The hospice nurse recommended staff use Tylenol for the rest of the night until the next day A Physician Order' dated 09/02/22, directed staff to provide oxygen at 2-5 liters, as needed, to keep oxygen level above 90 percent (%). On 12/12/22 at 02:37 PM, Certified Nurse Aide (CNA) MM stated she translated Spanish to English a lot for R293 and her family who could understand but not really speak much English. On 12/12/22 at 03:33 PM, Administrative Nurse D verified the facility had not developed a comprehensive care plan for R293's care including ADLs, communication, hHospice services, dietary, or oxygen treatment. The facility's Comprehensive Care Plan Policy, dated February 2021, directed staff to complete a comprehensive care plan that was individualized, and met the resident's medical, nursing, and mental needs. The facility failed to develop a comprehensive care plan for R293's immediate health and safety needs, including dietary, ADL assistance, respiratory and communication, placing R293 at risk to receive inadequate care and services related to her health and safety.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 92 residents. The sample included 22 residents. Based on observation, interview, and record review the facility failed to review and revise the care plan for Resident (R)51 regarding her use of supplemental oxygen and R34 for dialysis (a process of purifying the blood of a person whose kidneys are not working normally) related care. This deficient practice placed R51 at risk for inadequate care related to her use of oxygen and R34 at risk for inadequate care related to dialysis. Findings included: - R51's Electronic Medical Record (EMR) documented diagnoses of pneumonia (severe inflammation of the lungs in which the alveoli (tiny air sacs) are filled with fluid), chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs), respiratory failure with hypoxia (low levels of oxygen in your body tissues), aspiration pneumonia (when food or liquid is breathed into the airways or lungs, instead of being swallowed), and a pulmonary abscess (pus-filled cavity in the lung surrounded by inflamed tissue and caused by an infection). The Significant Change Minimum Data Set (MDS), dated [DATE], documented intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS documented R51 required supervision for eating, hygiene, transfers, toileting, and limited assistance of one staff for bed mobility, walking, and dressing. The MDS documented R51 had shortness of breath with exertion, received antibiotics and oxygen therapy. The ADL Care Area Assessment (CAA), dated 11/10/22, documented R51 was recently readmitted to the facility from the hospital following treatment for sepsis (severe infection) and pneumonia. The Respiratory Care Plan, dated 11/15/22, directed staff to give medications as ordered by the physician and monitor for side effects and effectiveness. Monitor for respiratory distress, anxiety, signs or symptoms of respiratory infection and report to the physician. The care plan lacked direction related to use of oxygen therapy. The Physician Oder, dated 09/04/22, directed staff to apply oxygen to maintain oxygen saturation greater than 90 percent (%). The Physician Oder, dated 09/09/22, directed staff to clean the oxygen concentrator filter and change the oxygen tubing weekly. The Progress Note, dated 10/29/22 at 10:51 AM, documented R51 experienced the following breathing issues: shortness of breath on exertion, has shortness of breath or trouble breathing when sitting at rest and her lung sounds were wheezes. R51 required oxygen at 4 liters (L) per minute. On 12/07/22 at 02:02 PM, observation revealed R51's oxygen concentrator had no filter and had lint on the uncovered intake grate. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/22 at 11:40 AM, observation revealed R51 stood by her wheelchair and her oxygen was hooked up to the tank on her wheelchair. The oxygen concentrator by her bed had no filter and had lint on the intake holes. On 12/07/22 at 03:50 PM R51 stated she used the oxygen tank when up and about, and the concentrator at night. On 12/12/22 at 12:00 PM, Licensed Nurse (LN) K stated staff were to change the oxygen tubing and concentrator filters weekly. LN K verified the lack of a filter and the lint on the filter holes of R51's oxygen concentrator and the tubing connected to the oxygen tank was undated. On 12/12/22 at 03:33 PM, Administrative Nurse D verified the care plan lacked direction related to use of oxygen therapy. Upon request the facility did not provide a policy for review and revision of care plans. The facility failed to review and revise R51's care plan to include the use of supplemental oxygen, placing R51 at risk for inadequate care related to her use of oxygen. - R34's Electronic Medical Record (EMR) documented diagnoses of end stage renal disease (ESRD-medical condition in which a person's kidneys cease functioning on a permanent basis), normocytic anemia (fewer red blood cells than normal), hypertension (high blood pressure), and atrial fibrillation (irregular and often very rapid heart rhythm). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired decision-making skill. The MDS documented R34 was independent for eating, required limited assistance of one staff for bed mobility, locomotion, hygiene, and extensive assistance of one staff for toileting, dressing, transfers and walking. The MDS documented R34 received anticoagulant (blood thinner) medications and received dialysis. The Urinary Care Area Assessment (CAA), dated 11/30/22, documented R34 had a diagnosis of end stage renal failure and received dialysis three times weekly. R34 continued to have urine output and requires assistance with toileting and incontinent care. The Care Plan, dated 11/23/22, documented R34 needed dialysis for a diagnosis of end stage renal failure and the dialysis access was located in the right forearm (R34's dialysis access was internal jugular vein port in the right neck/upper chest area). The care plan directed staff do not draw blood or take blood pressure in the arm with the graft (R34 had no graft); encourage resident to go for the scheduled dialysis appointments. Resident received dialysis three times weekly; monitor access site to right forearm (access site in neck) for function, signs of infection, irritation, bleeding, and consult physician as indicated. The 11/30/22 care plan update directed staff to monitor intake and output; monitor and report to the physician any signs or symptoms of infection to the access site and report significant changes in pulse, respirations and blood pressure immediately. The facility did not revise R34's Care Plan with the correct dialysis information. The Progress Note, dated 11/23/22 at 02:53 PM recorded the resident had dialysis Monday, Wednesday and Friday and needed to be there at 06:15 AM. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated 11/25/22 at 11:45 PM recorded a blood pressure of 88/53 milligrams of mercury (mmHg) with a pulse of 64 beats per minute. Staff notified R34's physician. R34 denied lightheadedness or vertigo (sensation of room spinning). He was alert and oriented. He transferred with assistance of two staff for toileting and his urine was dark amber. He had a right internal jugular dialysis port with the dressing dry and intact. R34 was out of the facility at that time for scheduled dialysis. The Progress Note, dated 12/12/22 (19 days after admission) at 12:27 PM, documented staff called the dialysis center with a concern that staff had not received any communication from them. The dialysis staff stated the resident never brought in any file or request for information. The dialysis center reported they would send the dry weight back after each appointment and also send a list of medications that were administered. The note went on to say the dialysis staff reported they watched R34's protein levels and gave him a snack if he needed one. The note documented staff ensured the facility and dialysis center had each other's contact information if there were further issues. Review of a blank Dialysis Communication Form, undated, revealed spaces for resident condition pre-dialysis for the facility to complete. The form had spaces for pre-dialysis and post dialysis information for the dialysis center to complete, and information areas for facility staff to complete upon return from dialysis. The facility lacked any forms used for R34's dialysis appointments. On 12/08/22 at 10:40 AM, observation revealed Licensed Nurse (LN) L checked R34's temperature, pulse, oxygen level, and dressing for the access site, a catheter in the upper right chest. The site dressing was clean, dry and intact. On 12/13/22 at 10:19 AM, Administrative Nurse D verified R34's Care Plan lacked correct dialysis access information. Upon request the facility did not provide a policy for revision of care plans. The facility failed to review and revise R34's care plan with correct dialysis information, care and services, placing the resident at risk inadequate care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 92 residents. The sample included 22 residents, with seven reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide consistent bathing services for Resident (R) 16 and R35. This placed the residents at risk for impaired dignity and skin issues. Findings included: - The Electronic Medical Record (EMR) for R16 documented diagnoses of schizophrenia (a psychiatric 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), narcissistic personality (a disorder in which a person has an inflated sense of self importance), and hypertension (high blood pressure). R16's Quarterly Minimum Data Set (MD), dated 08/03/22, documented R16 had intact cognition and required set-up assistance and supervision of transfers, mobility, dressing and personal hygiene. The MDS further documented bathing did not occur during the look-back period. The Annual MDS, dated [DATE], documented R16 had intact cognition and required extensive assistance of one staff for personal hygiene, and limited assistance of one staff for transfers and dressing. The MDS documented bathing did not occur during the look-back period. The ADL Care Plan, dated 11/13/22, documented R16 preferred a shower twice per week and documented at times, R16 would refused his showers. The September and October 2022 Bathing and Facility Bathing Sheets documented R16 requested showers on Tuesday and Friday dayshift and documented R16 had not received a bath or shower during the following days: 09/02/22-09/19/22 (18 days) 09/21/22-10/06/22 (16 days) 10/12/22-10/31/22 (20 days) The EMR documented R16 refused his shower one time in October and did not refuse any in September. The November 2022 Bathing and Facility Bathing Sheets documented R16 requested showers on Tuesday and Friday dayshift and documented R16 had not received a bath or shower during the following days: 11/01/22-11/30/22 (30 days) The EMR documented R16 refused his shower three times in November. (continued on next page)

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Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December 2022 Bathing and Facility Bathing Sheets documented R16 requested showers on Tuesday and Friday dayshift and documented R16 had not received a bath or shower during the following days: 12/01/22-12/12/22 (12 days) The EMR lacked documentation R16 refused his showers. On 12/07/22 at 02:02 PM, observation revealed R16's shirt was dirty with dried food debris down the front of his shirt. On 12/13/22 at 09:30 AM Certified Nurse Aide (CNA) O stated she had just started as bath aide a week ago and was unsure if the resident refused his showers. CNA O further stated, if residents refused, she wrote on the shower sheet and tried again later. CNA O said if the resident still refused, she told the nurse and at the end of her day she would also chart in the computer the refusal or the shower. On 12/13/22 at 09:45 AM Licensed Nurse (LN) J stated R16 did refuse his showers sometimes and she would continue to try to get him to take the shower or offer different times and days. On 12/13/22 at 01:01 PM Administrative Nurse D stated she expected staff to try to get the resident to shower at least once a week or offer a bed bath. Upon request, a policy for bathing was not provided from the facility. The facility failed to provide consistent bathing for R16, placing the resident at risk for complications related to poor hygiene. - The Electronic Medical Record (EMR) documented R35 had diagnoses of hypertension (high blood pressure), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), unsteadiness on feet, and peripheral neuropathy (weakness and numbness in the hands and feet). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R35 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of nine, and required supervision and set-up assistance of one staff for bed mobility, transfers, dressing, an did not ambulate. The MDS further documented bathing did not occur during the look back period. R35's Significant Change MDS, dated [DATE], documented R35 had moderately impaired cognition with a BIMS of 10 and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The ADL Care Plan, dated 10/28/22, documented R35 preferred showers two or three times per week. The September and October 2022 Bathing and Facility Bathing Sheets documented R35 requested showers on Wednesday and Saturday evening and documented R35 had not received a bath or shower during the following days: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/01/22-09/16/22 (16 days) 09/25/22-10/04/22 (10 days) 10/20/22-10/31/22 (12 days) The EMR documented R35 refused her showers one time in September and two times in October. The November 2022 Bathing and Facility Bathing Sheets documented R35 requested showers on Wednesday and Saturday evening and documented R35 had not received a bath or shower during the following days: 11/03/22-11/29/22 (27 days) The EMR documented R35 refused her shower three times in November. The December 2022 Bathing and Facility Bathing Sheets documented R35 requested showers on Wednesday and Saturday evening and documented R35 had not received a bath or shower during the following days: 12/04/22-12/09/22 (6 days) The EMR lacked documentation R35 refused her showers in December. On 12/08/22 at 10:35 AM, observation revealed R35's hair was greasy and disheveled. On 12/13/22 at 09:30 AM Certified Nurse Aide (CNA) O stated she had just started as bath aide a week ago and was unsure which residents refused their showers. CNA O further stated, if residents refused, she wrote on the shower sheet and tried again later. CNA O said if the resident still refused, she told the nurse and at the end of her day she would also chart in the computer the refusal or the shower. On 12/13/22 at 09:45 AM, Licensed Nurse (LN) J stated R35 did not refuse her showers that she knew of and if she did she would continue to try to get her to take the shower or offer different times and days. On 12/13/22 at 1:01 PM, Administrative Nurse D stated she expected staff to try to get the resident to shower at least once a week or offer a bed bath. Upon request, a policy for bathing was not provided from the facility. The facility failed to provide consistent bathing for R35, placing the resident at risk for complications related to poor hygiene.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25671 The facility had a census of 92 residents. The sample included 22 residents with four reviewed for pressure ulcers (wound to skin and underlying tissue resulting from prolonged pressure on the area). Based on observation, record review and interview, the facility failed to involve the Registered Dietician (RD) for nutritional interventions for one of four sampled residents, Resident (R) 72, who developed a facility acquired pressure ulcer. This placed the resident at risk to worsen his current pressure ulcer or develop more skin issues. Findings included: - The Physician Order Sheet, dated 12/02/22, recorded R72 had diagnoses of Parkinson's Disease (progressive disease of the central nervous system marked by tremors, muscular rigidity, and uncontrolled movements), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and muscle weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded R72 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) with rejection of care behaviors. The MDS recorded R72 required extensive staff assistance with bed mobility, transfers, used a wheelchair for mobility, was incontinent of bowel and urine, at risk for pressure ulcers, and had no skin issues The Activities of Daily Living (ADLs) Care Plan, dated 11/09/22, recorded R72 had self-care performance deficit related to muscle weakness, impaired balance, limited mobility, and limited range of motion. The ADLs Care Plan directed staff to provide extensive assistance with toileting, and to check R72 for incontinence every two to three hours to ensure the resident was clean and dry. Review of R72's medical record lacked documentation staff developed a care plan to address pressure ulcer prevention and wound care. The Wound Evaluation Report, dated 12/08/22, recorded R72 had developed a superficial pressure ulcer on the lower right buttock that measured 2.0 centimeters (cm) in diameter. The Wound Evaluation Report recorded R72 spent most of the day in his wheelchair, was incontinent of bowel and urine, and the resident frequently rejected incontinent cares. The Physician Order, dated 12/08/22, directed staff to cleanse the wound, cut alginate (medication used for wound and tissue healing) to fit the wound bed and cover the wound with border foam every day. The 12/11/22 at 06:52 PM, Behavior Progress Note recorded R72 rejected multiple staff offers for toileting and to offload the pressure on his buttock pressure ulcer. The Behavior Progress Note recorded staff educated R72 about the risks of his pressure ulcer worsening and/or developing infection, but the resident continued to decline care offers. Review of R72's clinical record lacked evidence the RD was notified and/or consulted regarding nutritional status after development of the pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/22 at 11:01 AM, observation revealed R72 sat in his wheelchair near the nurse station and refused two staff offers for toileting and/or resting in bed before lunch. On 12/12/22 at 02:48 PM, observation revealed Licensed Nurse (LN) G changed the dressing on R72's right buttock pressure ulcer. Observation revealed the old dressing intact, the superficial wound bed was pink with a scant amount of serosanguinous drainage (liquid with blood), measured 1.5 cm in diameter, and had no signs of infection. On 12/12/22 at 02:59 PM, LN G stated R72 continued to be non-compliant with toileting cares and resting in bed to off load the pressure off the wound. LN G stated staff should have notified the RD to complete a nutritional assessment for wound healing. On 12/13/22 at 08:03 AM, LN H stated R72 spends most of the day in his wheelchair, had a pressure ulcer on his right buttock and usually rejected toileting cares and resting in bed. LN H stated R72 had no nutritional supplements for wound healing. On 12/13/22 at 09:12 AM, Consultant RD GG stated staff had not notified her of R72's pressure ulcer. She said if she were notified, she would complete a nutritional assessment and recommend supplements to enhance wound healing. On 12/13/22 at 09:51AM, Administrative Nurse D stated staff should develop a care plan to R72's pressure ulcer care needs and notify the RD for nutritional interventions. The facility's Pressure Ulcer Policy, dated March 2022, directed staff to develop a care plan to implement interventions to prevent pressure ulcers and/or promote wound healing. The Pressure Ulcer Policy directed staff to consult the RD for nutritional interventions to aid wound healing. The facility failed to involve the RD for nutritional interventions for R72, placing the resident at risk to worsen his current pressure ulcer or develop more skin issues.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 92 residents. The sample included 22 residents, with six reviewed for accidents. Based on observation, record review, and interview, the facility failed to prevent a fall for Resident (R) 35, who fell from her wheelchair due to non-functioning brakes, and obtained a femur fracture (broken thigh bone). The facility further failed to assess R33, who was a fall risk, for the use of side rails. This placed the residents at risk for injury. Findings included: - The Electronic Medical Record (EMR) documented R35 had diagnoses of hypertension (high blood pressure), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), unsteadiness on feet, and peripheral neuropathy (weakness and numbness in the hands and feet). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R35 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of nine, and required supervision and set-up assistance of one staff for bed mobility, transfers, dressing, and did not ambulate. The MDS further documented R35 had unsteady balance, no functional impairment, and had no falls. R35's Significant Change MDS, dated [DATE], documented R35 had moderately impaired cognition with a BIMS of 10, and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented R35 had unsteady balance, lower functional impairment on one side, and a recent fracture repair. The Fall Care Area Assessment (CAA), dated 10/28/22, documented R35 was alert with impaired memory function, poor decision-making skills and safety awareness, required assistance with daily care needs, transfers, mobility, and had a history of a fall with injury. The Fall Assessments, dated 05/28/22 and 10/28/22 documented a high risk for falls. The Fall Assessments, dated 08/27/22, documented a low risk for falls. The Fall Care Plan, dated 03/26/22, documented R35 needed gripper strips on the floor beside the bed and directed staff to ensure R35 had appropriate footwear on when ambulating and mobilizing in her wheelchair. The update, dated 10/17/22, directed staff to put gripper strips on the floor beside the bed. The update, dated 11/05/22 directed staff to install anti-rollbacks to R35's wheelchair, encourage participation in skilled rehabilitation services for mobility and safety, and place a sign in R35's room reminding her to ask for assistance when needing items close to the floor. The care plan further directed to monitor the wheelchair brakes routinely for effective use, and consult maintenance as indicated for the need of assessment or repair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Investigation, dated 10/16/22 at 10:30 AM, documented R35 was found on the floor in her room by housekeeping staff. The resident stated she transferred herself to the wheelchair, and it rolled backwards as the locks on the wheelchair were broken. The investigation further documented R35 stated she did not hit her head but fell on her knee. The investigation documented R35 could move all extremities, did not complain of pain, and was transferred back into bed. The Nurse's Notes, dated 10/16/22 at 06:26 PM, documented R35 had right knee pain and an order for an X-ray (image of internal structures) was obtained. The X-Ray Report, dated 10/16/22, documented R35 had a minimally displaced oblique (slanting) fracture through the distal femoral diaphysis (a femur fracture), and she was admitted to the hospital. The Nurse's Note, dated 10/19/22 at 04:30 PM, noted R35 readmitted back to the facility. The facility was unable to provide any documentation that staff checked the wheelchair brakes for functionality. On 12/08/22 at 10:35 AM, observation revealed R35 laid in her bed, Certified Nurse Aide (CNA) M and CNA N sat R35 up in her bed and R35 stated They don't do a good job at transferring me. CNA N took R35's legs and moved them off of the bed as R35 stated watch my right hip. Further observation revealed CNA M placed a gait belt around R35's waist and the resident stated, you've never put that on me before. Continued observation revealed CNA M placed her right arm under R35's right arm and CNA N placed her left arm under R35's left arm and started to transfer R35. R35 started to scream and reported that the staff were hurting her chest and it felt as though staff were ripping her chest off. CNA M and CNA N quickly placed the resident back on the bed and then the two staff grabbed the gait belt and the back of the resident's pants and quickly transferred her into the wheelchair. CNA M stated, I think she is putting on a show for you, she is being dramatic. On 12/08/22 at 10:35 AM, R35 stated she transferred herself into her wheelchair on 10/16/22. She thought the brakes were locked but they were broken. R35 said when she went to sit down, the wheelchair flipped and she fell out of it, and broke her leg. On 12/08/22 at 10:45 AM, CNA M stated R35 fell out of her wheelchair because the brakes were not working. On 12/08/22 at 03:30 PM, Administrative Nurse D stated wheelchair brakes were checked weekl y when the wheelchairs were cleaned on the night shift. Administrative Nurse D further stated there was no documentation from the night shift that the brakes were not functioning properly until after R35 fell . On 12/08/22 at 03:30 PM, Maintenance Staff Q stated the wheelchair brakes were repaired when R35 came back from the hospital. On 12/13/22 at 09:45 AM, Licensed Nurse (LN) J stated night shift staff cleaned wheelchairs at night and checked to make sure the wheelchair brakes and foot pedal on the wheelchair were working properly; if there were concerns that the brakes may be broken, a report was made for maintenance to work on the wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/13/22 at 01:16 PM, Administrative Nurse D stated she expected staff to check the wheelchairs for proper functioning when they were being cleaned and if there were problems, staff should have made a report sheet out, gave it to her, and she would report it to maintenance. On 12/13/22 at 03:24 PM, Consultant KK stated he expected the facility to check wheelchair brakes for proper functioning and further stated he assumed there was a schedule for the wheelchairs to be checked and any maintenance completed for wheelchairs in the facility. Consultant KK further stated if staff were supposed to be checking wheelchairs during cleaning, that should have been done. The facility's Fall policy, dated 09/17/22, documented the fall management program was to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life. The fall management program promoted safety, prevention, and education of both staff and residents. The facility shall ensure that a fall management program would be maintained to reduce the incidence of falls and risks and injury to the resident and promote independence and safety. The facility did not provide a policy for wheelchair maintenance. The facility failed to ensure R35's wheelchair brakes were properly functioning which caused a fall. As a result of the fall, R35 sustained a femur fracture. 25671 - The Physician Order Sheet, dated 12/02/22, recorded R33 had diagnoses of alcohol induced dementia (persistent mental disorder marked by memory loss and impair reasoning), major depressive disorder (mental illness characterized by depressed mood and significant loss of interest in life activities), insomnia (problems falling and/or staying asleep), and muscle weakness The Quarterly Minimum Data Set (MDS), dated [DATE], recorded R33 had a Brief Interview for Mental Status (BIMS) score of three (severely impaired cognition) with inattention and disorganized thinking. The MDS recorded R33 was independent with bed mobility and transfers, had impaired balance, and received antipsychotic (medication used to treat severe mental illness), antidepression (medication used to treat mood changes), antianxiety (medication used to treat agitation and restlessness) and opioid (narcotic medication used to treat moderate to severe pain) medications seven days a week. The Accident and Fall Care Plan, dated 10/20/22, recorded R33 was assessed a high risk for falls due to impaired cognition, poor safety awareness, incontinence, and a history of falls. The Accident and Fall Care Plan recorded R33 had trouble sleeping, had poor impulse control, and required staff supervision and assistance with decision making. R33's Accident and Fall Care Plan lacked documentation for the use of side rails. The Fall Risk Assessment, dated 10/17/22, recorded R33 was a high risk for falls due to cognitive impairment, limited mobility, use of assistive devices and history of falls. Review of R33's medical record lacked documentation the facility completed evaluation for the appropriate and safe use of side rails. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/07/22 at 03:34 PM, observation revealed R33 sat on the bed watching TV, and the upper side rails were raised on both sides of the bed. Continued observation revealed R33 could pass her extremities through the gaps in the side rails. On 12/08/22 at 01:12 PM, Certified Nurse Aide (CNA) Q stated R33 had trouble sleeping, frequently transferred out of bed without staff assistance and was a fall risk. On 12/12/22 at 11:06 AM, Licensed Nurse (LN) G stated R33 was a fall risk due to cognitive impairment, poor balance and impulsive behaviors, and the resident should not have the side rails raised on her bed. LN G stated R33 spent most of her time in bed, had trouble sleeping and frequently transferred herself out of bed. LN G stated she was not aware of a side rail assessment to evaluate R33's safe use of side rails. On 12/13/22 at 09:47 AM, Administrative Nurse D stated staff should complete an assessment to evaluate R33's safe use of side rails related to the resident's history of falls and the side rails had gaps that could entrap the resident. The facility's Side Rail policy, dated October 2022, directed staff to complete routine side rail assessments to ensure the resident's need, appropriateness, and safety for the use of side rails. The facility implemented side rails for R33 without a safety assessment or accident hazard care plan, placing the resident at risk for entrapment and falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 92 residents. The sample included 22 residents with two reviewed for respiratory treatment. Based on observation, interview, and record review the facility failed to provide adequate respiratory care and services regarding Resident (R)51's use of supplemental oxygen. This deficient practice placed R51 at risk for less than optimal oxygen therapy. Findings included: - R51's Electronic Medical Record (EMR) documented diagnoses of pneumonia (severe inflammation of the lungs in which the alveoli (tiny air sacs) are filled with fluid), chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs), respiratory failure with hypoxia (low levels of oxygen in your body tissues), aspiration pneumonia (when food or liquid is breathed into the airways or lungs, instead of being swallowed), and a pulmonary abscess (pus-filled cavity in the lung surrounded by inflamed tissue and caused by an infection). The Significant Change Minimum Data Set (MDS), dated [DATE], documented intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS documented R51 required supervision for eating, hygiene, transfers, toileting, and limited assistance of one staff for bed mobility, walking, and dressing. The MDS documented R51 had shortness of breath with exertion, received antibiotics and oxygen therapy. The ADL Care Area Assessment (CAA), dated 11/10/22, documented R51 was recently readmitted to the facility from the hospital following treatment for sepsis (severe infection) and pneumonia. The Respiratory Care Plan, dated 11/15/22, directed staff to give medications as ordered by the physician and monitor for side effects and effectiveness. Monitor for respiratory distress, anxiety, signs or symptoms of respiratory infection and report to the physician. The care plan lacked direction related to use of oxygen therapy. The Physician Oder, dated 09/04/22, directed staff to apply oxygen to maintain oxygen saturation greater than 90 percent (%). The Physician Order, dated 09/09/22, directed staff to clean the oxygen concentrator filter and change the oxygen tubing weekly. The Progress Note, dated 10/22/22 at 08:56 PM, documented R51 was transferred via ambulance to the hospital for a change in condition, abnormal vital signs, coarseness and crackles in lungs, chills, and an oxygen saturation of 72-84%. The Progress Note, dated 10/26/22, documented R51 returned to the facility. The Progress Note, dated 10/29/22 at 10:51 AM, documented R51 experienced the following breathing issues: shortness of breath on exertion, has shortness of breath or trouble breathing when sitting at rest and her lung sounds were wheezes. R51 required oxygen at 4 liters (L) per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated 10/31/22 at 09:59 AM, documented R51's family requested staff to send R51 to the emergency room (ER). The Physician Order, dated 11/3/22, directed staff to administer Augmentin (antibiotic) 875-125 milligrams (mg) by mouth two times a day for pneumonia until 12/01/2022. On 12/07/22 at 02:02 PM, observation revealed R51's oxygen concentrator had no filter and had lint on the uncovered intake grate. On 12/12/22 at 11:40 AM, observation revealed R51 stood by her wheelchair and her oxygen was hooked up to the tank on her wheelchair. The oxygen concentrator by her bed had no filter and had lint on the intake holes. On 12/07/22 at 03:50 PM, R51 stated she used the oxygen tank when up and about, and the concentrator at night. On 12/12/22 at 12:00 PM, Licensed Nurse (LN) K stated staff were to change the oxygen tubing and concentrator filters weekly. LN K verified the lack of a filter and the lint on the filter holes of R51's oxygen concentrator and the tubing connected to the oxygen tank was undated. On 12/12/22 at 03:33 PM, Administrative Nurse D stated she expected staff to change oxygen tubing and wash the oxygen concentrator filters weekly. Upon request the facility did not provide a policy regarding the care of oxygen equipment and tubing. The facility failed to provide adequate respiratory care and services regarding R51's use of supplemental oxygen, placing R51 at risk for less than optimal oxygen therapy and for potential infections.

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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** 26768 The facility had a census of 92 residents. The sample included 22 residents with one reviewed for dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, interview and record review the facility failed to provide care and services for Resident (R) 34 with regard to his dialysis access when staff did not routinely assess the access site and lacked ongoing communication between the dialysis center and facility. This deficient practice placed R34 at risk for avoidable complications related to dialysis. Findings included: - R34's Electronic Medical Record (EMR) documented diagnoses of end stage renal disease (ESRD-medical condition in which a person's kidneys cease functioning on a permanent basis), normocytic anemia (fewer red blood cells than normal), hypertension (high blood pressure), and atrial fibrillation (irregular and often very rapid heart rhythm). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired decision-making skill. The MDS documented R34 was independent for eating, required limited assistance of one staff for bed mobility, locomotion, hygiene, and extensive assistance of one staff for toileting, dressing, transfers and walking. The MDS documented R34 received anticoagulant (blood thinner) medications and received dialysis. The Urinary Care Area Assessment (CAA), dated 11/30/22, documented R34 had a diagnosis of end stage renal failure and received dialysis three times weekly. R34 continued to have urine output and requires assistance with toileting and incontinent care. The Care Plan, dated 11/23/22, documented R34 needed dialysis for a diagnosis of end stage renal failure and the dialysis access was located in the right forearm (R34's dialysis access was internal jugular vein port in the right neck/upper chest area). The care plan directed staff do not draw blood or take blood pressure in the arm with the graft (R34 had no graft); encourage resident to go for the scheduled dialysis appointments. Resident received dialysis three times weekly; monitor access site to right forearm (access site in neck) for function, signs of infection, irritation, bleeding, and consult physician as indicated. The 11/30/22 care plan update directed staff to monitor intake and output; monitor and report to the physician any signs or symptoms of infection to the access site and report significant changes in pulse, respirations and blood pressure immediately. The Progress Note, dated 11/23/22 at 02:53 PM recorded the resident had dialysis Monday, Wednesday and Friday and he needed to be there at 06:15 AM. The Progress Note, dated 11/25/22 at 11:45 PM recorded a blood pressure of 88/53 milligrams of mercury (mmHg) with a pulse of 64 beats per minute. Staff notified R34's physician. R34 denied lightheadedness or vertigo (sensation of room spinning). He was alert and oriented. He transferred with assistance of two staff for toileting and his urine was dark amber. He had a right internal jugular dialysis port with the dressing dry and intact. R34 was out of the facility at that time for scheduled dialysis. (continued on next page)

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	175274	A. Building B. Wing	12/13/2022

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated 12/12/22 (19 days after admission) at 12:27 PM, documented staff called the dialysis center with a concern that staff had not received any communication from them. The dialysis staff stated the resident never brought in any file or request for information. The dialysis center reported they would send the dry weight back after each appointment and also send a list of medications that were administered. The note went on to say the dialysis staff reported they watched R34's protein levels and gave him a snack if he needed one. The note documented staff ensured the facility and dialysis center had each other's contact information if there were further issues. Review of a blank Dialysis Communication Form, undated, revealed spaces for resident condition pre-dialysis for the facility to complete. The form had spaces for pre-dialysis and post dialysis information for the dialysis center to complete, and information areas for facility staff to complete upon return from dialysis. The facility lacked any forms used for ongoing communication between the dialysis center and the facility. On 12/08/22 at 10:40 AM, observation revealed Licensed Nurse (LN) L checked R34's temperature, pulse, oxygen level, and dressing for the access site, an IJ catheter in the upper right chest. The site dressing was clean, dry and intact. On 12/08/22 at 01:01 PM, Administrative Nurse D stated the facility did not have R34's batch orders for dialysis in the charting system. Administrative Nurse D stated nurses were to monitor for bleeding every evening, but she did not expect them to assess the resident or site prior to sending to the dialysis center. On 12/08/22 At 02:00 PM, Consultant Nurse HH verified the lack of assessment of R34's dialysis port. On 12/13/22 at 10:19 AM, Administrative Nurse D verified R34's care plan lacked correct dialysis access information. The facility's Hemodialysis Access Care policy, dated 01/2017, documented there was more risk of clotting and infection when a central catheter is used rather than fistulas or grafts for dialysis access. The policy directed staff to check for signs of infection at the access site when performing routine care and when palpating for thrill and listening for bruit. The nurse should document in the medical record appearance of the site if a central catheter was used, and notification of the medical practitioner of any issues with the dialysis access site. The facility failed to provide care and services for R34 with regard to his dialysis access when staff did not routinely assess the site, and lacked evidence of ongoing communication between the dialysis center and facility, placing R34 at risk for avoidable complications of dialysis.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25671 The facility had a census of 92 residents. The sample included 22 residents with six reviewed for accident hazards. Based on observation, record review and interview, the facility failed to complete an assessment for the safe use of side rails for one sampled resident, Residents (R) 33. This placed the resident at risk for entrapment and injuries related to side rail use. Findings included: - The Physician Order Sheet, dated 12/02/22, recorded R33 had diagnoses of alcohol induced dementia (persistent mental disorder marked by memory loss and impair reasoning), major depressive disorder (mental illness characterized by depressed mood and significant loss of interest in life activities), insomnia (problems falling and/or staying asleep), and muscle weakness The Quarterly Minimum Data Set (MDS), dated [DATE], recorded R33 had a Brief Interview for Mental Status (BIMS) score of three (severely impaired cognition) with inattention and disorganized thinking. The MDS recorded R33 was independent with bed mobility and transfers, had impaired balance, and received antipsychotic (medication used to treat severe mental illness), antidepression (medication used to treat mood changes), antianxiety (medication used to treat agitation and restlessness) and opioid (narcotic medication used to treat moderate to severe pain) medications seven days a week. The Accident and Fall Care Plan, dated 10/20/22, recorded R33 was assessed a high risk for falls due to impaired cognition, poor safety awareness, incontinence, and a history of falls. The Accident and Fall Care Plan recorded R33 had trouble sleeping, had poor impulse control, and required staff supervision and assistance with decision making. R33's Accident and Fall Care Plan lacked documentation for the use of side rails. The Fall Risk Assessment, dated 10/17/22, recorded R33 was a high risk for falls due to cognitive impairment, limited mobility, use of assistive devices and history of falls. Review of R33's medical record lacked documentation the facility completed evaluation for the appropriate and safe use of side rails. On 12/07/22 at 03:34 PM, observation revealed R33 sat on the bed watching TV, and the upper side rails were raised on both sides of the bed. Continued observation revealed R33 could pass her extremities through the gaps in the side rails. On 12/08/22 at 01:12 PM, Certified Nurse Aide (CNA) Q stated R33 had trouble sleeping, frequently transferred out of bed without staff assistance and was a fall risk. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/22 at 11:06 AM, Licensed Nurse (LN) G stated R33 was a fall risk due to cognitive impairment, poor balance and impulsive behaviors, and the resident should not have the side rails raised on her bed. LN G stated R33 spent most of her time in bed, had trouble sleeping and frequently transferred herself out of bed. LN G stated she was not aware of a side rail assessment to evaluate R33's safe use of side rails. On 12/13/22 at 09:47 AM, Administrative Nurse D stated staff should complete an assessment to evaluate R33's safe use of side rails related to the resident's history of falls and the side rails had gaps that could entrap the resident. The facility's Side Rail policy, dated October 2022, directed staff to complete routine side rail assessments to ensure the resident's need, appropriateness, and safety for the use of side rails. The facility failed to complete an assessment for the safe use of side rails for R33, placing the resident at risk for entrapment and injuries related to side rail use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 92 residents. The sample included 22 residents, with three reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care. Based on observation, record review, and interview, the facility failed to provide the necessary person-centered dementia care to attain the highest practicable physical, mental, and psychosocial well-being for one sampled resident, Resident (R) 194, who had multiple incidents of behaviors and resident-to-resident altercations. This placed the resident at risk for injury and unmet physical and psychosocial needs. Findings Included: - The Electronic Medical Record (EMR) for R194 documented diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (a feeling of worry, nervousness, or unease). The Admission Minimum Data Set (MDS), dated [DATE], documented R194 had moderately impaired cognition and was dependent upon two staff for toileting, extensive assistance of two staff for dressing, supervision and set-up assistance for ambulation. R194 was independent with set-up assistance for bed mobility and transfers. The assessment further documented R194 had no behaviors and received an antipsychotic (medication used to manage psychotic disorders) and antidepressant (a medication used to treat depression and anxiety). R194's Significant Change MDS, dated [DATE], documented R194 had severely impaired cognition and was dependent upon two staff for toileting, bathing and extensive assistance of two staff for bed mobility, transfers, dressing, and supervision and set-up assistance for ambulation. The MDS further documented R194 had inattention, physical behaviors directed towards others, other behaviors, rejected care, and wandered four to six days. The MDS documented R194 received antipsychotic, antidepressant, antianxiety (medication used to treat anxiety), and opioid (narcotic used to treat pain) medication. The Care Plan, dated 11/29/22, initiated on 04/22/22, documented R194 was resistive to cares and could be physically aggressive towards staff and other residents. The care plan directed staff to administer antipsychotic medications as ordered, monitor for side effects and effectiveness, obtain behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes, contact the physician as needed, and use the facility behavior monitoring protocols. The Nurse's Note, dated 07/06/22 at 07/06/22, documented R194 punched a staff member in the face while staff attempted to move him away from another resident as he was touching other residents. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note, dated 07/15/22 at 02:08 PM, documented R194 grabbed a Certified Nurse Aide (CNA), pushed him against the wall and punched him in the face multiple times. The note further documented the CNA put his hands up to block the resident from continuing to hit him; staff intervened and R194 just walked away. The Emergency Report, dated 07/15/22 at 04:56 PM, documented R194 was seen for Alzheimer's and agitation in dementia. The report further documented R194 would be discharged back to the facility as they did not have any open beds for admission to the behavioral unit. The Nurse's Note, dated 07/16/22 at 03:11 AM, documented R194 returned to the facility with four-point restraint (restrains both arms and both legs), which were removed and an order for risperidone (an antipsychotic medication), 0.5 milligrams (mg), by mouth, twice a day was obtained. The Nurse's Note, date 07/16/22 at 10:27 AM, documented R194 was pounding on the walls, yelling out, defecated on the floor twice, and urinated on the walls several times. The noted further documented the physician ordered Haldol (an antipsychotic medication), 5 mg, intramuscular (im) injection to be administered at that time. The Nurse's Note, dated 07/18/22 at 09:06 AM, documented R194 struck R64 which caused R64 to fall to the ground hitting the back of his head. The Nurse's Note, dated 07/18/22 at 10:50 AM, documented R194 was still agitated and staff were 1:1 with the resident; he tried to shove a table in the dining room into another resident. The note further documented staff intervened and the physician was notified. The Nurse's Note, dated 07/18/22 at 11:03 AM, documented R194 assaulted R54 in the dining room, shoved a dining room table into R54's abdomen and tried to push him down. The note further documented staff separated the residents and assessed R54 for injury. The note further document R194 was sent to a behavioral hospital for evaluation and treatment. The Nurse's Note, dated 07/18/22 at 02:40 PM, documented R194 was admitted to a behavioral unit for evaluation and treatment. The Nurse's Note, dated 08/03/22 at 02:40 PM, documented R194 returned from the behavioral unit, resisted care from staff and lifted chairs and tried to push the chairs against the glass window. The Nurse's Note, dated 08/04/22 at 11:34 AM, documented R194 tried to pull a television from the wall and pushed chairs against the glass window. The The Nurse's Note, dated 08/10/22 at 07:18 PM, documented R194 tried to grab R64's neck and the Certified Nurse Aide moved him when he placed one hand on R64's neck. The Psychiatric Note, dated 11/09/22 documented R194 was agitated and restless, grabbed at her notes and did not have impulse control. The Nurse's Note, dated 09/20/22 at 08:41 AM, documented R194 ripped out the air conditioner cover inside of his room. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note, dated 09/30/22 at 05:58 PM, documented R194 went into R53's room, picked up a television and dropped it, breaking it but the television continued to work and R53 wanted to keep the television. The Nurse's Note, dated 10/04/22 at 07:55 AM, documented R194 bit R88 on the hand and attempted to bite R64. The note further documented staff would notify the physician. The Nurse's Note, dated 10/04/22 at 06:29 PM, documented R194 went into R53's room, and made a mess. The Nurse's Note, dated 10/04/22 at 07:51 PM, documented R194 was violent, threw equipment, turned over tables and tried to bite another resident. The note further documented R194 was combative with staff that tried to intervene, and urinated on the floor. The Nurse's Note, dated 10/14/22 at 03:23 PM, documented R194 pushed an unidentified resident which caused the resident to fall to the floor. The note further documented the unidentified resident complained of back pain. The note documented staff contacted the physician. The Nurse's Note, dated 10/24/22 at 01:16 PM, documented R194 entered R53's room, picked up the television and tried to hit R53 with it. The note further documented R53 stood up from the bed, yelled at R194 and when R194 would not leave the room, R53 shoved R194 which caused R194 to fall to the ground and obtained a small skin tear. The note documented staff intervened, contacted family, physician and administration. The Psychiatric Note, dated 11/09/22 documented she was unable to assess the resident as he was unable to answer questions, wandered in the hallway, and appeared to not have impulse control. The note directed staff to continue with current medication and to continue to monitor mood. The EMR documented R194 passed away on 11/29/22. On 12/13/22 at 09:40 AM, Certified Medication Aide (CMA) R stated R194 was very aggressive, destructive and [NAME] to redirect. CMA R further stated R194 had a lot of resident-to-resident altercations and staff had to separate him from other residents. CMA R stated when there were altercations, she called the nurse to assess. CMA R stated they receive dementia and behavior training through their computer education. On 12/13/22 at 11:30 AM, Licensed Nurse (L) H stated R194 would get angry and tried to take food from other residents and that would start a problem, LN H further stated she wrote in progress notes when there were altercations and notified the doctor, administration, and family. LN H stated they had sent R194 to the behavioral unit and have done multiple medication changes for him but staff did not know what else to do. On 12/13/22 at 01:01 PM, Administrative Nurse D stated she had not completed an investigation to try to determine causative factors for all of R194's incidents. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Behavioral Assessment, Intervention, and Monitoring policy, documented staff would identify, document, and inform the medical practitioner about specific details regarding changes in an individual's mental status, behavior and cognition. The interdisciplinary team would evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident change of condition. Safety strategies would be implemented immediately if necessary to protect the resident and others for harm. The facility failed to provide the necessary person-centered dementia care for R194, who had multiple incidents of behaviors and resident-to-resident altercations. This placed the resident at risk for injury and unmet needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37450 The facility had a census of 92 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to monitor medication room refrigerator temperatures of one of two medication rooms, and lock one of five medication carts which placed residents at risk receiving ineffective medication stored in the medication room refrigerator and leave an unattended, unlocked medication cart which placed residents at risk of unintended ingestion/loss of medications. Findings included: - On 12/07/22 at 08:31 AM during initial tour of the medication room located behind the nurse's station near the entrance of the facility, observation revealed a small black refrigerator with a September 2022 temperature log with five temperatures recorded. The temperature log was attached to the refrigerator door, no logs found for October 2022, November 2022, or December 2022. Certified Medication Aide (CMA) PP stated staff should have completed the logs. On 12/07/22 at 10:21 AM observation revealed a medication cart located on the 300-hallway unlocked, and unattended by staff. On 12/07/22 at 10:21 AM CMA S approached the medication cart and stated the medication should have been locked. On 12/13/22 at 01:48 PM, Administrative Nurse D verified the medication room refrigerators temperature should be logged on a daily basis. Administrative Nurse D stated CMA S should not have left the medication cart unlocked and unattended. The facility's Medication Storage in the Facility policy, dated 05/2019, documented medications and biologicals are stored safely, securely and properly following manufacture or supplier recommendation. Medication requiring refrigeration or temperature between 36 degrees Fahrenheit and 46 degrees are kept in the refrigerator. The facility's Storage and Return of Drugs, dated 04/2021, documented the resident's medications shall be properly labeled and stored at or near the nurse's station in a locked cabinet, a locked medication room or is in one or more locked mobile medication carts of satisfactory designed for such storage. All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored either in a locked room or otherwise made immobile. The facility failed to monitor medication room refrigerator temperature of one medication room and lock one of five medication carts which placed residents at risk for receiving ineffective medication and risk of unintended ingestion/loss of medication.

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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** 25671 The facility had a census of 92 residents. The sample included 22 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to notify the physician of elevated blood sugars out of the physician ordered parameters for Resident (R) 72 and failed to complete a physician ordered laboratory test for R36. This placed the residents at risk for adverse side effects and health problems. Findings included: - The Physician Order Sheet, dated 12/02/22, recorded R72 had diagnoses of diabetes mellitus (disease that affects the body ability to produce or respond to insulin and regulate blood sugar levels), Parkinson's disease (progressive disease of the central nervous system marked by tremors, muscular rigidity, and uncontrolled movements), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and muscle weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded R72 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) with rejection of care behaviors. The MDS recorded R72 required extensive staff assistance with bed mobility, transfers, used a wheelchair for mobility, and had not received insulin (hormone used to control blood glucose levels) injections. Review of R72's medical record lacked documentation staff developed a care plan to address diabetes care and insulin use. The Physician Order, dated 12/05/22, directed staff to check R72's blood sugar before meals and at bedtime, and call the physician per blood sugar parameters. The Physician's Order, dated 12/06/22, directed staff to administer Novolog insulin (fast acting insulin that helps lower mealtime blood sugars spikes) per a sliding scale (progressive increase in insulin related to blood sugar levels) to R72 and notify the physician if blood sugars were greater than 451 milligrams per decilitre (mg/dl). Review of R72's December 2022 Medication Administration Record (MAR) revealed the following blood sugars above the physician ordered parameters and no documentation of assessment or physician notification: 12/06/22 at 11:39 AM - 528 mg/dl 12/06/22 at 12:19 PM - 528 mg/dl 12/07/22 at 11:35 AM - 496 mg/dl 12/07/22 at 12:37 PM - 498 mg/dl 12/08/22 at 02:03 PM - 520 mg/dl (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/10/22 at 12:52 PM - 460 mg/dl On 12/12/22 at 12:01 PM, observation revealed the resident sat in his wheelchair at the dining table eating lunch. On 12/12/22 01:27 PM, Licensed Nurse (LN) I stated the nurse checked R72's blood sugar four times a day (before meals and before bedtime), and if the resident had an elevated blood sugar above the physician's parameters, the nurse should assess R72 and notify the physician. On 12/13/22 at 09:47 AM, Administrative Nurse D stated staff should check R72's blood sugar as ordered by the physician and notify the physician if the resident's blood sugar was above the physician ordered parameters. Upon request the facility failed to provide a policy for blood sugar monitoring. The facility failed to notify the physician of R72's elevated blood sugars out of the physician ordered parameters, placing the resident at risk for continued elevated blood sugars and adverse side effects. 26768 - R36's Electronic Medical Record (EMR) documented diagnoses including a fractured femur (thigh bone) and dementia (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired decision-making skill. The MDS documented R36 had delusions (belief or altered reality that is persistently held despite evidence or agreement to the contrary), and no behaviors. The MDS documented R36 required limited assistance of one staff for eating and extensive assistance of two staff for all other activities of daily living (ADLs) and had a fall with fracture and surgery prior to admission. The MDS documented R36 received scheduled pain medication, antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), antidepressant (medications used to treat mood disorder) and anticoagulant (medications used to thin the blood) medications seven days of the lookback period. The Psychotropic Medication Care Area Assessment (CAA), dated 11/02/22, recorded R36 had daily use of antipsychotic and antidepressant medications. It documented staff monitored medication effectiveness, signs of adverse effects related to use with referral to physician and/or psychiatric services as indicated. The Medication Care Plan, dated 11/06/22, directed staff to monitor for signs of fluid imbalance including increased edema (swelling), moist lung sounds, shortness of breath, abnormal lab results and consult the physician as indicated. The care plan directed staff to obtain and monitor labwork as ordered, report results to the physician and follow up as indicated. The Physician Order, dated 10/30/22, directed staff to obtain weekly labwork including a Complete Blood Count (CBC) and Basic Metabolic Profile (BMP). The EMR lacked documentation of labwork for 11/21/22 and 12/05/22. (continued on next page)

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

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/07/22 at 03:45 PM, observation revealed R36 in bed, watching TV. R36 stated she had mild pain in her back and received pain medications for it. On 12/12/22 at 03:33 PM, Administrative Nurse D verified the facility had not obtained the physician ordered labwork for 11/21/22 and 12/05/22. Upon request the facility did not provide a policy regarding medication administration and/or labwork. The facility failed to monitor the effectiveness of R36's medication through physician ordered labwork, placing R36 at risk to receive unnecessary drugs.

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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** 32360 The facility had a census of 92 residents. The sample included 22 residents. Based on observation, interview and record review the facility failed to ensure the resident received drinks consistent with her preferences for Resident (R)86 who requested milk with every meal. This deficient practice placed R86 at risk to not have her rights and choices respected. Findings included: - R86's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure), gastroesophageal reflux disease (GERD-occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach), and a history of ileus (obstruction of the bowel). The Admission Minimum Data Set (MDS), dated [DATE], documented R86 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The MDS documented R86 was independent with eating, required extensive assistance of two staff for dressing, toileting, and total staff assistance for bed mobility and transfers. The MDS documented R86 weighed 325 pounds (lbs.) and had no swallowing or dental problems. The Nutrition Care Area Assessment (CAA), dated 11/15/22, documented a diagnosis of morbid obesity (chronic disease defined by too much body fat that puts your health at risk). R86's appetite was good, and she fed herself without difficulty. The Nutrition Care Plan, dated 11/08/22, directed staff to encourage adequate nutrition, offer small frequent feedings, educate the resident about: the importance of maintaining a normal weight for height, the value of regular exercise, limiting salt intake, and the importance of medication and maintaining diet compliance. The Physician Order, dated 11/09/22, directed staff to provide a regular diet, regular texture, and regular liquid. The EMR lacked assessment of the resident's dietary likes, dislikes, or preferences. On 12/07/22 at 09:20 AM, observation revealed R86 in bed with her breakfast tray on the bedside table. R86 stated she requested milk with every meal and had not received milk for most meals. On 12/12/22 at 11:33 AM, R86 stated for breakfast today she received a hardboiled egg, a half of a piecea piece of ham, and toast. She stated the menu stated French toast for today. R86 stated she received milk after requesting it twice. R86's breakfast menu ticket stated milk, and oatmeal. On 12/12/22 at 02:46 PM, Dietary Staff BB stated if a resident does not have a specific physician order, the facility generally only provided milk for breakfast and dinner, not lunch. He stated the resident would need a dietary order for lunch time milk. Dietary Staff BB stated if a resident wrote milk on the lunch ticket they may get it, if it would not cause the facility to run out of milk for the other meals. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/22 at 03:33 PM, Administrative Nurse D stated staff did not obtain dietary preferences and the resident received what was on the menu or an alternative. The staff asked residents preferences for the next meal. Administrative Nurse D stated R86 wanted milk and fresh fruit with every meal, and staff filled out the form and gave it to dietary. Administrative Nurse D verified no follow through was done and R86 should have milk if wants. The facility's Resident rights policy, dated 2018, stated residents had the right to choose foods from a menu, based on likes and dislikes. The facility did not provide a policy regarding food choices. The facility failed to ensure R86 received drinks consistent with her preferences when she requested milk with every meal but was not allowed to have milk with lunch. This deficient practice placed R86 at risk to not have her rights and choices respected.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37450 The facility had a census of 92 residents. The sample included 22 residents. Based on observation, record review and interview, the facility failed to store, prepare, and serve food under sanitary conditions for meals prepared in the facility's kitchen, which placed the residents at risk of consuming contaminated food. Finding included: - On 10/07/22 at 08:35 AM, observation revealed Dietary Staff (DS) CC present in the kitchen. DS CC had two to three inches of facial hair not contained in a beard guard. DS CC confirmed he had been cooking and serving meals. On 12/12/22 at 01:09 PM observations made during the midday meal preparation and serving revealed: A staff member' s soda can sat on a food prep table across from the three-compartment sink. The three-compartment sink had brown tarry/sticky substance on the plastic plumbing pipes underneath with a clear plastic square full of cloudy water. The three-compartment sink sanitation testing strips had an expiration date of 05/15/22. The floor under the stove/grill lacked floor tile with unfinished floor exposed. The exhaust hood register type venting above the stove/grill and fryer had a large amount of sticky brown, grey debris throughout surface of horizonal slats. The stainless steel shelving had rusting and a sticky brownish substance; the shelves had food preparation bowls directly stored on the lowest shelf. The four-square ceiling vent had dark fuzzy substance on the corners. A white square box fan sat in a south window, facing inward, and had grey, fuzzy material on the blades and screen. The dining room attached to the kitchen had three ceiling fans with grey fuzzy substance on all the fan blades. The ceiling surrounding the center ceiling fan had dark grey substance attached in the circumference of the fan. The dining room south wall corner near the kitchen entrance had an open drain and water plastic piping with unfinished flooring exposed without barrier to warn resident or staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/12/22 at 01:09 PM Dietary Staff (DS) BB, stated staff's soda can should not have been sitting on a food prep table and threw it in the trash. DS BB verified sticky, tarry, fuzzy type substances on plastic piping, shelving, vents, box fan, ceiling fan blades in the dining, square ceiling vents in the kitchen, and added these areas to the cleaning schedule. DS BB also verified the floor under the stove without finished flooring and in the dining room with exposed drain and water plastic piping. DS BB stated a beard guard should be worn if staff have facial hair. The facility's Healthcare Service Group and its Subsidiaries Equipment HCSG 027 policy, dated 09/2017, documented all food service equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's direction and training material. All food contact equipment will be cleaned and sanitized after every use. All food contact equipment will be clean and free of debris. The facility's Healthcare Service Group and its Subsidiaries Equipment HCSG 028 policy, dated 09/2017, documented all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary conditions. The Dining Service Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. The Dining Service Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storages, and surfaces. The facility failed to store, prepare, and serve food under sanitary conditions for meals prepared and served in the kitchen and dining room which placed the residents at risk of consuming contaminated food.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 32360 The facility had a census of 92 residents. Based on observation, record review, and interview, the facility failed to maintain an effective quality assessment and assurance (QAA) program to develop corrective actions plans and monitor them to correct identified quality deficiencies prior to survey. This deficient practice placed the residents at risk for ineffective care. Findings included: - The facility failed to address repeated concerns in resident council. (Refer to F565) The facility failed to provide a clean, sanitary environment for one of five units in the facility. (Refer to F584) The facility failed to prevent incidents of neglect and resident-to-resident abuse. (Refer to F600) The facility failed to identify and report incidents of resident-to-resident abuse to the State Agency (Refer to F609) The facility failed to investigate incidents of resident-to-resident abuse. (Refer to F610) The facility failed to provide bed hold notification with hospitalization . (Refer to F625) The facility failed to provide consistent assistance for bathing. (Refer to F677) The facility failed to prevent a fall with a fracture for R35 after her wheelchair brakes were not functioning and she fell out of her wheelchair. (Refer to F689) The facility failed to provide appropriate respiratory care and services. (Refer to F695) The facility failed to monitor R34's dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) site and lacked communication with the dialysis center. (Refer to F698) The facility failed to assess side rails for R33, who was a fall risk. (Refer to F700) The facility failed to provide individualized care and services related to dementia care. (Refer to F744) The facility failed to employ a certified dietary manager. (Refer to F801) The facility failed to maintain a sanitary kitchen and dining room. (Refer to F812) The facility failed to maintain a water management program for water borne pathogens and failed to wear PPE in a resident room who was on droplet precautions. (Refer to F880) (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to provide influenza and/or pneumococcal immunizations. (Refer to F883) The facility failed to provide Covid-19 immunization. (Refer to F887) On 12/13/22 at 03:22 PM, Administrative Staff A stated that the Quality Assurance Performance Improvement (QAPI) team met monthly to discuss concerns identified in the facility. She identified concerns of bathing, falls, infection control, and falls. Administrative Staff A stated she was unsure of any performance improvement plans (PIPS) the facility was working on now. Administrative Staff A stated she had only been with the facility for two months and was working hard on team work to develop a better environment for the 92 residents who reside in the facility. Upon request a policy for the facility's QAPI was not provided by the facility. The facility failed to identify and develop corrective action plans for potential quality deficiencies through the QAPI process to correct identified quality issues, this deficient practice placed the resident's at risk for ineffective care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37450 The facility had a census of 92 residents. The sample included 22 residents. Based on observation, record review, and interview the facility failed to adhere to infection control practices for COVID-19 (a virus which is characterized mainly by fever and cough, and is capable of progressing to severe symptoms and in some cases causes death especially in older people, and those with underlying health conditions) droplet isolation precautions which placed the residents who resided in the facility at increased risk for contracting COVID-19 infection and failed to implement a water management program for the Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease or heavy tobacco use are most at risk of developing a pneumonia caused by Legionella). This placed the residents in the facility at risk for infectious disease. Findings Included: - On 12/12/22 at 07:57 AM, observation revealed the facility main entry door with a posted sign of positive COVID-19 residents at that time and directed visitors to wear masks and to follow the Centers for Disease Control and Prevention (CDC) recommendations related to social distancing. On 12/12/22at 08:06 AM, Licensed Nurse (LN) G reported the facility had six COVID-19 positive residents. On 12/12/22 at 08:06 AM, observation revealed Certified Medication Aide (CMA) T donning a yellow gown, gloves, KN95 facial mask, and face shield, to enter a resident's room on the 300-hall which had a Droplet Precautions sign posted on the door. On 12/13/22 at 12:48 PM, observation revealed CMA S deliver a Styrofoam box to a 300-Hall resident room with a posted Droplet Precaution sign on the door. CMA S entered the room but had not donned a gown, face shield, or gloves. When CMA S left the room, she stated she was unaware the resident was on COVID-19 precautions. On 12/13/22 at 01:15 PM, Administrative Nurse E stated the staff (including CMA S) working on the 300-hall had been verbally informed of the COVID-19 positive residents and had placed a Droplet Precaution sign posted on the door. On 12/13/22 at 01:46 PM, Administrative Nurse D verified CMA S should have donned personal protective equipment (PPE) when going into COVID-19 positive resident rooms. On 12/13/22 at 05:45 PM, Administrative Nurse E reported the current number of residents' positive for COVID-19 had increased to 12 residents. Upon request the facility did not provide a Droplet Precaution policy. The facility failed to adhere to infection control practices for droplet precautions for COVID-19 positive residents which placed the residents who resided in the facility at increased risk for COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 12/13/22 at 12:55 PM, Maintenance Staff U stated he had the testing material for the water management process but he had not performed any testing or done anything with it yet. Maintenance Staff U explained the process was very encompassing and said he was going to reach out to the corporation to assist him with establishing a process. The facility's undated Water Management Program, documented the purpose of the document is to define the policy of water management plan/program and to minimize the growth and transmission of the Legionella bacteria and other waterborne pathogens within the community. The policy further documented the requirements will be met by the following actions: inspection of water storage tanks (monthly), visual inspection of hot water Calorifiers (coiled heated exchanges (annually), visual inspections of temperatures and settings of Calorifiers (monthly), temperature of hot and cold water outlets at Sentinel taps (monthly), Legionella water samples taken (annually) and tested , flushing of infrequently used water outlets/faucets (weekly), check other outlets on a rotation basis/schedule over a 12 month period (recording temperatures, in a log book). A Legionella management team has a day to day responsibility for management of the risk of exposure to Legionella Bacteria. All Legionella Management team personnel will be made aware of their responsibilities. The facility failed to implement a water management program to test and manage waterborne pathogens placing the residents who reside in the facility at risk of contracting Legionella pneumonia.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 92 residents. The sample included 22 residents. Based on record review and interviews the facility failed to obtain immunization status, provide immunization, or obtain an informed declination for five residents, Resident (R) 13, R34, R33, R81, and R82, with the current Center of Disease Control and Prevention (CDC) influenza (flu) and/or pneumococcal (pneumonia-respiratory illness) immunization which placed the residents at risk for contracting influenza or pneumonia. Findings included: - Upon immunization record review revealed: R13's admitted [DATE], the Electronic Medical Record (EMR) lacked influenza and pneumococcal immunization status and lacked evidence the immunization was offered and/or declined. R33's admitted [DATE] EMR lacked pneumococcal immunization status and lacked evidence the immunization was offered and/or declined. R34's admitted [DATE] EMR lacked pneumococcal immunization status and lacked evidence the immunization was offered and/or declined. R81's admitted [DATE] EMR lacked pneumococcal immunization status and lacked evidence the immunization was offered and/or declined. R82's admitted [DATE] EMR lacked pneumococcal immunization status and lacked evidence the immunization was offered and/or declined. On 12/12/22 at 04:00 PM Administrative Nurse E stated she would like to have residents' immunization records updated in the EMR within two weeks of admission. Administrative Nurse E reported the facility did not have a system in place for checking and recording immunization status for the influenza and pneumococcal needs. The facility's Pneumococcal Vaccine Program, dated 2019, documented It is the policy of this facility that residents will be offered immunization against pneumococcal disease. Pneumococcal illness is a serious illness that can cause sickness and even death. The rate among the elderly mortality may be as high as 61%. Primary care physicians will be asked that all new admissions be screened and given both pneumococcal vaccines. according to ACIP recommended schedule, unless specifically ordered otherwise by the physician on admission orders. Upon admission follow the standing order protocol to determine eligibility to receive the vaccine. If resident is eligible provide education to the resident or the resident's representative regarding the benefits and potential side effects of the immunization. the resident or the resident's representative has the opportunity to refuse the immunization. If immunization is refused, document the education and refusal in the medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Influenza Vaccine Program, dated 2019, It is the policy of this facility that annually residents are offered immunization against influenza. This facility follows the recommendations of the CDC and any State Department of Health recommendations for Influenza vaccinations in the facility including each resident is offered an influenza vaccine October 1 through March 31 annually unless the immunization is medically contraindicated, already immunized or after the provision of education on risks and benefits choose to refuse. The facility failed to obtain immunization status, provide immunization, or obtain an informed declination for five residents for influenza and/or pneumococcal immunization which placed the residents at risk for contracting influenza or pneumonia.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 92 residents. The sample included 22 residents. Based on record review and interviews the facility failed to obtain immunization status, provide immunization, or obtain an informed declination for three of five sampled residents, Resident (R) 13, R34, and R82, for COVID-19 (highly contagious, potentially fatal respiratory virus) immunization which placed the residents at increased risk for contracting COVID-19. Findings included: - Upon immunization record review revealed: R13's admitted [DATE], the Electronic Medical Record (EMR) lacked COVID-19 immunization status and lacked evidence the immunization was offered and/or declined. R34's admitted [DATE] EMR lacked COVID-19 immunization status and lacked evidence the immunization was offered and/or declined. R82's admitted [DATE] EMR lacked COVID-19 immunization status and lacked evidence the immunization was offered and/or declined. On 12/12/22 at 04:00 PM Administrative Nurse E stated she would like to have the residents' immunization records updated in the EMR within two weeks of admission. Administrative Nurse E reported the facility did not have a system in place for checking and recording immunization status for the COVID-19 immunization. Upon request the facility failed to provide a COVID-19 resident immunization policy. The facility failed to obtain immunization status, provide immunization, or obtain an informed declination for R13, R34, and R82, for COVID-19 immunization which placed the residents at increased risk for contracting COVID-19.