STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40688 The facility identified a census of 100 residents. The sample included 27 residents with three residents reviewed for personal property. Based on observation, record review and interview, the facility failed to identify and maintain Resident(R)46's personal property, eyeglasses brought to the facility, to support his right to maintain his independence as practicable. Findings included: - R46's diagnoses, listed under the Diagnosis tab in the electronic medical record (EMR), included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and cancer of the throat. The Admission Minimum Data Set (MDS), dated [DATE], recorded R46 had a Brief interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R46 required supervision with set-up to limited assistance of one staff member for most activities of daily (ADLs) except eating for which he was dependent on staff. The MDS recorded R46 had adequate vision and used corrective lenses. The MDS recorded R46 indicated in an interview it was very important to him to take care of his personal belongings. The Care Plan created on 07/08/21 recorded R46 was at risk for a communication problem. An intervention created on 07/08/21 directed staff to use alternative communication as needed which included communication book/board, writing pad, gestures, signs, and pictures. The Care Plan created on 07/07/21 documented R46 had little or no activity involvement due to his poor adjustment to the facility. An intervention dated 07/07/21 directed R46 enjoyed watching different movies, drawing, and playing poker. The Care Plan lacked direction regarding R46's glasses and/or vision needs. The Admission assessment dated [DATE] under the Assessment tab in the EMR recorded R46 had impaired vision. It indicated R46 wore corrective lenses and documented R46's corrective lenses were present on admission. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The unsigned, undated Inventory of Personal Effects scanned under the Misc. tab in the EMR documented the resident had various articles of clothing, an electronic tablet, and a cellular phone with chargers. The Inventory of Personal Effects lacked documentation of a pair of glasses. On 08/05/21 at 08:21 AM, R46 sat in his room on his bed. Observation revealed R46 with visible difficulty operating his TV remote, holding it upside down and unable to see which button controlled the volume. When R46 was shown a card in effort to facilitate communication, R46 stated he could not see what was on the card because his glasses were lost. He stated they had been lost for several weeks. He stated he had alerted some nursing staff but did not want to say who for fear there would be trouble. R46 stated he would like to have his glasses if possible and reported it was very difficult to see without them. On 08/05/21 at 11:39 Certified Nurse Aid (CNA) O stated if a resident reported a missing item, staff were to fill out a form and give it to social services. She stated staff would check with laundry to see if laundry had spotted the item. CNA O stated staff were supposed to document residents' personal items on their inventory. She also reported she had never really seen the resident inventory form, but she knew it existed. CNA O was unsure if R46 had glasses or had reported missing items. On 08/05/21 at 02:13 PM Social Services X stated staff should assist the residents if needed in reporting a missing item. She reported the social services department was responsible for following up on missing items and residents' concerns. She explained facility staff had been educated on the use of the grievance form to report resident concerns and listed the locations of the boxes and forms if a resident or family member wanted to make an anonymous report. She stated for lost items like glasses and dentures, they typically required an appointment and social services assisted in making the appointment and scheduling the resident's transportation in order to facilitate the replacement of those items. Social Services X said all facility staff were responsible in ensuring the residents had the items they needed, and all staff should be assisting in maintaining residents' personal property. She further said nobody had filled out a form regarding R46's missing glasses. Social Services X assured she would follow up with R46 to remedy the situation. The facility policy on Quality of Life; Homelike Environment revised on 05/2020 documented all items brought in were marked and listed on the resident Inventory of Personal Effects form, either by staff or family. The facility failed to identify and maintain R46's eyeglasses which had the potential to affect his overall wellbeing including the potential for decreased communication, and decreased ability to enjoy preferred activities.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 100 residents. The sample included 27 residents; two residents sampled for Advanced Directive (a written document which indicated the medical decisions for health care professionals when the person could not speak) review. Based on observations, record review, and interviews, the facility failed to update Point Click Care (PCC- Electronic Medical Record [EMR] system) to accurately reflect the Do Not Resuscitate (DNR) code status for Resident (R) 96 when she readmitted to the facility and failed to ensure a lawful DNR form was maintained by the facility for R46 who had a DNR that was not signed by the physician. This deficient practice had the risk for miscommunication regarding resident's code status and incorrect actions regarding life-saving measures. Findings included: - R96 admitted to facility on [DATE], discharged to the hospital [DATE], and readmitted to facility [DATE]. The Diagnoses tab of R96's EMR documented diagnoses of major depressive disorder (major mood disorder), muscle weakness, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R96 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated [DATE], documented R96 had cognitive loss/dementia and was at risk for complications. The Care Plan dated [DATE], documented R96 was admitted to hospice for metabolic encephalopathy and directed staff consulted with physician and social services to have hospice care for resident in the facility. The care plan lacked direction on code status. The Orders tab of R96's EMR documented an order with a start date of [DATE] for code status of full code (CPR- emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.). The Miscellaneous (MISC) tab of R96's EMR revealed a scanned DNR form signed by R96's durable power of attorney (DPOA- legal document that names a person to make healthcare decisions when the resident was no longer able to) on [DATE] and signed by physician on [DATE]. The Notes tab of R96's EMR revealed a Nursing Note on [DATE] at 11:06 PM that documented R96 was admitted to hospice and R96 was aware of the situation but could not comprehend. R96 was a DNR at that moment. On [DATE] at 08:13 AM, R96 laid in bed with her eyes closed. She appeared comfortable and without signs of distress or discomfort. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:40 PM, Social Services Y stated when a resident admitted from the hospital, the admitting nurse placed the code status in the computer then social services reviewed it with the resident. She stated the code status was located at the top of the face sheet on PCC and if there was a code status change, medical records changed it. On [DATE] at 12:47 PM, Administrative Nurse B stated once a DNR form is signed, it was uploaded then medical records changed it in the EMR. She stated staff looked at the top of PCC for code status. She stated when a resident readmitted to the facility, the admitting nurse should be reviewing the MISC tab of the EMR to see what code status the resident was previously. On [DATE] at 01:29 PM, Certified Nurse Aide (CNA) N stated code status was in Point of Care (POC- CNA charting EMR system) and was easily seen. On [DATE] at 03:38 PM, Licensed Nurse (LN) FF stated code status was found on the care profile in PCC and was located on the new cheat sheets the staff used. She stated hospital discharge paperwork was sent to medical records and the admission coordinator reviewed the information. On [DATE] at 04:10 PM, Administrative Nurse D stated hospital discharge paperwork was reviewed by herself or the Assistant Director of Nursing (ADON) and they placed the orders in the computer. The admitting nurse verified the code status with the resident on admission. She stated the code status should be in the orders and in the care plan. The facility failed to provide a policy on Advanced Directives. The facility failed to update the EMR to accurately reflect the code status of DNR for R96 when she readmitted to the facility. This deficient practice had the risk for miscommunication regarding R96's code status and incorrect actions regarding life-saving measures. 40688 - R46's diagnoses, listed under the Diagnosis tab in the EMR, included chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), severe protein-calorie malnutrition, and malignant neoplasm of the pharynx (throat cancer). The Admission Minimum Data Set (MDS), dated [DATE], recorded R46 had a Brief interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R46 required supervision with set-up to limited assistance of one staff member for most activities of daily (ADLs) except eating for which he was dependent on staff. The Care Plan did not address R46's advance directives or DNR code status. The Orders tab of R46's EMR recorded the following order, dated [DATE] and signed by Consultant HH for DNR. A Nursing Note dated [DATE] at 11:15PM under the Progress Note tab in R46's EMR recorded LN H assisted R46 with his belongings and admission paperwork. R46 stated at that time I am a DNR, please don't try to save me. The note documented LN H noted that in R46's chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A scanned document, under the Misc. tab in R46's EMR revealed a Out of the Hospital DNR form signed by LN H on [DATE] and signed by R46 on [DATE]. The form lacked the required physician signature. On [DATE] at 09:30 AM R46 laid in bed and watched television. He had a clean dressing placed around his tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted) and a minimal amount of secretions noted at the tracheostomy opening. R46 verbally confirmed his desire for DNR status though as unable to verify his signature on the signed DNR form as he stated his glasses were missing and he could not see the form well enough. On [DATE] at 02:13 PM Social Services X stated nursing staff was typically the first facility staff to discuss advance directive and resuscitative preferences with the residents. She stated the forms must be signed by a physician or a nurse practitioner and then the form would be sent to medical records once it was completed to be scanned into the resident's health record. On [DATE] at 03:49 PM Administrative Nurse D stated code status was reviewed with the resident at admission and again at each care plan meeting. She said the admitting nurse would review and sign the form with the resident. After the form was signed by the resident and witnessed by a staff member, the form would go to the physician to be signed. Administrative Nurse D stated the physician was required to sign the DNR form for the DNR to be legally in effect. The facility did not provide a policy related to advance directives. The facility failed to ensure R46's advance directive form for DNR was signed by the physician as required. This deficient practice placed R46 at risk to be deprived his right to his documented and self-stated wishes regarding his resuscitative status.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40688 The facility reported a census of 100 residents. Based on observation, record review and interviews, the facility failed to maintain a safe, clean, homelike environment when the facility failed to secure chemicals, hygiene items, soiled linens and trash out of the reach of the residents. The facility further used the common areas and hallways to store large medical equipment such as wheelchairs, transfer poles, lifts and linen carts which increased the risk for accidents and created an institutionalized environment. The facility failed to maintain sanitary conditions and failed to ensure the area remained free of unpleasant odors. Findings included: On [DATE] at 07:21 AM the common area at the nurse's station on Kensington unit smelled of urine. There were five unidentified residents seated in the area. On [DATE] at 07:22 AM on the Kensington unit, a bottle of Virex (all-purpose disinfectant cleaner) hung on the fire extinguisher in the hall. On [DATE] at 07:23 AM the shower room on the middle hall on Kensington had the door propped open. The sink was soiled, with a hairbrush with no name/identification on the sink edge with multiple hairs stuck in it. There was soiled clothing piled in a chair and slipper socks on the floor. The commode in the shower room had dark amber liquid in the bowl as well as dried yellow splatters on the seat. The area had an odor of urine. The storage closets were open and unlocked and contained spray bottles of wound cleanser, multiple bottles of aftershave, and shaving cream. The cabinet also contained a metal spoon, a metal butter knife, and multiple adult incontinence briefs unbagged and laying on the floor inside the lower cabinet. On [DATE] at 07:26 AM an unknown cart type with four pvc pipes sticking up from each corner was parked in the open, unsecured storage area. There were piles of wadded up clear plastic in between the four posts and on the floor next to the cart. There was a Hoyer lift (mechanical lift) with a black nd yellow sling draped over the top and two visibly soiled wheelchairs with crumbs in the seats in the area as well. Two blue wedge pillows laid on the floor in the corner of the area. On [DATE] at 07:30 AM in the dining room between Kensington and Serenity unit, there was a motorized wheelchair with an opened bag of adult incontinence briefs on the seat. An empty plastic bag labeled [NAME] Durable Floor Finish laid on one of the dining room tables. The mini refrigerator in the dining room contained a one third full gallon of milk, which expired on [DATE]. There was an unlabeled, undated bowl of unidentifiable food partially frozen inside the refrigerator as well. The refrigerator temperature was 32 degrees Fahrenheit and there was a thick layer of frost over the inside back and inside top of the refrigerator. On the counter next to the refrigerator was an open, half full bottle of water with no name or date. On [DATE] at 07:37 AM the storage area across from nurse station on Kensington unit had a dirty linen cart protruding from the area into the hallway. The soiled linen cart had a half full cup of water with no lid and a bag of trash can liners on top of it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 07:38 AM the North hall on Kensington unit had a strong urine odor. On [DATE] at 07:39 AM the North hall on Kensington unit had several areas of broken and chipped plaster on the wall, above the plastic floor trim. On [DATE] at 07:41 AM an unlocked clean linen closet on the Kensington North hall had an uncovered plastic bin of unmated socks on the floor. On [DATE] at 07:42 AM an unlocked storage room on the Kensington (dementia) unit had three plastic dispensers of bleach wipes on the counter as well as a spray bottle of Spartan Nabc Cleaner (nonacid toilet and bathroom cleaner). Also, on the counter in this unsecured room was an open, clear plastic round container with dark amber liquid in it with two dead flies floating in the liquid. There was a trash can with a used incontinence brief or chuck in it. The room had a strong urine odor. On [DATE] at 07:48 AM the inside of the door to room [ROOM NUMBER] had multiple chips and peeling in the wood grain laminate type with rough edges and exposing wood underneath. room [ROOM NUMBER] had the same chipping on the inside of the door. The open common area at the end of the North hall had multiple wheelchairs with visibly soiled cushions, pillows, linens and a used surgical mask piled in the seats. There was a metal transfer pole laying on the floor. There were many flies in the area. On [DATE] at 07:54 AM the common area at the nurse's station on Kensington unit had a tray stacked with dirty dishes, some Styrofoam some plastic. There was dried food on the plates which appears to be stew and vegetables from the previous night's dinner. On [DATE] at 08:16 AM on the 100 hallway mechanical lifts were parked in front of the exit door at the end of the hall. There were boxes and cushions on the floor in the same area. The handrails on the 100 hall were noted with chipped, flaking paint. On [DATE] at 09:45 AM R67's room has multiple care items (briefs, creams etc.) stored atop a bedside stand. The electric pump connected to the low air loss mattress sat on the floor, connected to the mattress with no clean barrier between the pump and the floor. A mattress leaned against the wall and partially covered the window. On [DATE] at 11:44 AM R74's room lacked a doorknob. R74 stated it had been off for at least two weeks. On [DATE] at 12:00 PM the middle hall on the Kensington unit had dried, brown sticky substance on the handrail. On [DATE] at 09:53 Maintenance U stated the maintenance team attempts to respond as quickly as possible to all work orders or reports of items needing repair. He stated the nursing staff have communication forms to use to alert maintenance of routine repairs but if it urgent or involves a resident area staff usually just call and Maintenance U or his teammate will respond. Maintenance U stated the pest control had been in the facility the previous day in response to a complaint about pests. Maintenance U stated he was aware of the flies upstairs. He also stated he had observed the yellow/brown liquid with the dead flies floating in it and had disposed of it as he did not know what it was. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:39 Certified Nurse Aid O stated it was all staffs' responsibility to ensure the environment was clean, and safe. She stated is messes occur, they should be cleaned as soon as possible and if it is a hazard, the hazard should be moved immediately. CNA O stated if items in the facility were broken, staff would write a communication sheet but if it was urgent, staff would just call. She stated the facility did have an issue with flies. On [DATE] at 12:30 PM Administrative Nurse E stated the common areas were the only place to store the large resident care items. She said the wheelchairs did not fit in the rooms. She further stated she did not expect items such as pillows, wedges, soiled linens, and used lift slings to be stored in the wheelchairs or in the hallways in general since staff would not know if it was clean or who it belonged to. The facility policy on Quality of Life; Homelike Environment revised on ,d+[DATE] recorded it was the policy of the facility to encourage and provide opportunities for each resident to occupy an area which reflected their interests, family or was made homelike by special decorations. The facility failed to maintain a safe, clean, homelike environment when the facility failed to secure chemicals, hygiene items, soiled linens and trash out of the reach of the residents. The facility further used the common areas, and hallways to store large medical equipment such as wheelchairs, transfer poles, lifts and linen carts which increased the risk for accidents and created an institutionalized environment. The facility failed to maintain sanitary conditions in resident care areas and failed to ensure the area remain free of unpleasant odors.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 40688 The facility identified a census of 100. The sample included 27 residents with 12 residents reviewed for abuse. The facility identified the Kensington unit as the dementia unit, with a census of 37 residents. Based on record review, observation, and interviews the facility failed to ensure the residents were free from abuse and neglect. Resident (R) 84, who had a history of aggressive behaviors and striking other residents entered R56's room and struck him in the face multiple times. On another occasion, R84 acted aggressively, then punched R47. Approximately two hours later, R84 hit R71. R21, who had a history of aggressive behaviors grabbed R15 and bent her over, and then on a later date R21 again grabbed R15, by the wrist, and attempted to bend her fingers back. The facility's failure to prevent abuse by R84 and R21 placed those residents on the dementia unit in immediate jeopardy. Further, the facility failed to ensure residents were free from neglect when the facility failed to provide the necessary care as defined in the comprehensive plan for care for R148. R148, who had a history of falls, was required to have hourly checks when in her room alone. The facility failed to provide the hourly check and during the time unattended, R148 obtained injuries consistent with a fall which included an acetabular fracture (pelvis fracture involving the hip joint). The injury necessitated an emergent transfer to an acute care setting where she required a surgical intervention to treat the fracture. Findings include: - R84's diagnoses, listed under the Diagnosis tab in the electronic medical record (EMR), included dementia with Lewy bodies (a progressive mental disorder characterized by failing memory, and confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and impulse disorder (a condition in which a person has trouble controlling emotions or behaviors). R84's Admission Minimum Data Set (MDS) on 04/12/21 recorded R84 had a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS recorded he wandered one to three days of the look back period which improved from his prior assessment. The 04/12/21 Behaviors Symptoms Care Area Assessment indicated R84's behaviors would be addressed in the plan of care. The Quarterly MDS dated [DATE] recorded R84's BIMS remained four. The MDS recorded R84 received limited assistance of one staff for locomotion on the unit in a wheelchair. The MDS documented R84 had behaviors, which included physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) for one to three days of the look back period. R84 had verbal behavioral symptoms directed at others (e.g. threatening, screaming, cursing) for one to three days of the look back period. Sections 0500 and 0600 of the MDS which addressed the impact R84's behaviors had on himself and other residents was incomplete. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R84's Care Plan, in the EMR under the Care Plan tab documented a focus dated 10/20/20 and revised on 07/14/21, which recorded R84 had actual physical behaviors (yelling, hitting) due to his dementia, schizophrenia, bipolar disorder, anger, depression, and poor impulse control. He had a history of harm to others. The focus also recorded resident to resident 10/20/20 resident to resident 10/21/20 resident to resident 07/13/21. The Care Plan interventions dated 10/21/20 directed staff to analyze key times, places, and triggers as well as what de-escalated the behaviors and document. It directed staff to assess and address for contributing sensory deficits, assess and anticipate the resident's needs: food, thirst, toileting needs, comfort level, body positioning, and pain. The Care Plan directed staff to document observed behavior, attempted interventions, and further directed staff to guide R84 away from sources of distress, engage him calmly in conversation. The Care Plan directed staff to walk calmly away, and approach later if R84's response to staff was aggressive. The Care Plan also documented the following interventions dated 10/21/21: Resident to resident 10/20/20. Resident [R84] went into another resident's room and hit [the] resident in the eye. Resident [R84] redirected back to his room and given snacks. Resident to resident 10/21/20. Resident [R84] went into another resident's room and started hitting [the] resident. Resident [R84] redirected to common area. Resident [R84] sitting with a one on one and plan to send resident [R84] to [hospital] for evaluation. Another intervention, dated 07/13/21 recorded Resident to resident 7/13/2021: Psychiatrist gave order for UA [urinalysis] and referral to [psychiatric hospital] for potential admission and change of condition for increased behaviors, aggressiveness towards other staff. The Progress Notes tab in R84's EMR recorded the following notes: A Nursing Note dated 10/20/20 at 02:06 PM recorded an unidentified Certified Medication Aid (CMA) and Social Worker alerted License Nurse (LN) G that R84 went into another unidentified resident's room and hit him the eye. LN G documented staff observed R84 wandering approximately 10 minutes prior to the incident but demonstrated no aggressive behaviors. A IDT [interdisciplinary] Note dated 10/21/20 at 07:00AM authored by Administrative Nurse D recorded the IDT team met to discuss the altercation. CMA and social worker notified LN G R84 went to another resident's room and hit him, R84 wandered in the common area approximately 10 minutes prior to the incident. R84 had no aggression noted after the incident. Staff easily redirected R84 to his room and offered snacks and supervision to ensure he stayed in his room. The note recorded an intervention of resident redirected to room and offered supervision with no signs of aggression or agitation noted. A Social Service Summary dated 10/21/20 at 09:00 AM authored by Social Services X documented R84 was a pleasant male with Lewy body dementia, admitted to the facility for long term care following a hospitalization . The note recorded R84 was previously at a long-term care facility, but he became agitated and combative with another resident and could not return there. A Nursing Note dated 10/21/20 at 03:50 PM authored by LN G documented R84 sat in the common area when he began to wander off the unit. Staff attempted to redirect R84 and he got upset and made repetitive aggressive statements. R84 then went into R56's room and began to hit R56 in his face while he laid in bed. R56 yelled out NO repeatedly. R84 then left R56's room with the unidentified social worker and sat in the common area. Staff contacted R84's representative and gave permission for R84 to be sent to the hospital if necessary. Staff notified the (unidentified) physician and the physician gave the order to transfer as needed. R84 was one to one observation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An IDT Note dated 10/21/20 at 04:37 PM authored by Administrative Nurse D recorded the IDT met to discuss the incident that occurred on 10/21/21. R84 sat in the common area where he began to wander on the unit. Staff attempted to redirect him, he became upset, and made aggressive statements. He then entered R56's room and began to hit R56 in the face while R56 laid in bed. R84 exited R56's room with a (unidentified) social worker and staff redirected the resident to sit in the common area. The note documented an intervention of R84 to be one to one observation and sent to the hospital for evaluation. A Nursing Note on 10/21/20 at 06:33 PM recorded R84 transferred to the hospital. A Nursing Note dated 10/22/20 at 02:15 AM recorded R84 returned to the facility from the hospital with a diagnosis of a urinary tract infection and orders for an antibiotic (medication used to treat bacterial infections). Review of the Facility Report dated 10/22/20 revealed the following account of the 10/21/20 incident: on 10/21/2020 at 03:45 PM a resident to resident altercation occurred between R84, who had a BIMS of 99 (unable to complete interview) and R56 who had a BIMS of six (severe cognitive impairment). Both residents resided on the locked memory care unit. On 10/21/20, R84 began wandering on the unit. Staff members attempted to redirect R84 and he became upset and made aggressive repetitive statements. R84 then went into R56 ' s room and began to hit R56 in his face while R56 was lying in bed. R56 was yelling out No, no, No. The social worker witnessed the incident and attempted to redirect R84. R56 attempted to defend himself by putting his left arm over his face. R84 then came out of the room with the social worker. Staff redirected R84 to the common area where he appeared calm with no agitation or aggression. Staff immediately initiated 1:1 constant supervision of R84. Staff notified Consultant HH and received orders to transfer to the hospital of choice for evaluation. Staff notified R84's durable power of attorney (DPOA) and they agreed with sending the resident to the emergency department for evaluation. R56 had two small scratches noted to his left forearm with no bruising or discoloration to the face at this time. R84 was unable to give a statement of why he struck R56. R84 did not answer any questions related to incident . Further review of Progress Notes tab in R84's EMR revealed the following: A Nursing Note dated 10/27/20 at 10:00 PM authored by LN H recorded R84 wandered and talked to himself. Staff closely monitored him and when they attempted to redirect him. R84 became agitated and swung at staff. LN L attempted to redirect R84 three times with the same result. R84 went into another resident's room and laid in that resident's bed. When staff attempted to assist R84 to his room, R84 screamed and threatened staff. Staff notified Consultant HH and received an order for Haldol (antipsychotic medicine that is used to treat schizophrenia) every eight hours as needed. Staff administered an injection of Haldol to R84. LN L obtained a (unidentified) male nurse to assist R84 to his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Nursing Note dated 07/13/21 at 03:00 PM authored by LN K recorded R84 sat in the common area when another (unidentified) male resident attempted to pass by. R84 told the other resident R84 was going to kill him. Both residents yelled at each other. R84 made a fist and lifted his hand to hit the other resident. LN K intervened and quickly moved the other resident. Both residents were angry. LN K explained to both residents that their behavior was inappropriate. R84 responded with cold, cold it's cold. R84 was alert, but oriented to his name only. At approximately 06:00 PM LN K heard R84, in the hallway coming back from the dining room, threaten someone. LN K ran over to see what was going on and saw R84 threaten a (unidentified) female resident. He attempted to hit her and missed. LN K again removed R84 from area and placed him in front of his room. At 06:05 PM R84 propelled himself to the common area and hit another (unidentified) resident in the face and chest with his fist. LN K again removed R84 and contacted the psych nurse NP [nurse practitioner] who gave new orders. The note documented staff notified Administrative Nurse E immediately after each incident. A Nursing Note dated 07/13/21 at 04:09 PM authored by LN K recorded the following At 4pm this writer observed resident [R84] sitting in his w/c [wheelchair] next to this writer when resident reached over and socked a female resident who was sitting in a chair next to him asleep, he hit her with his fist saying do you want to die. this writer removed the resident with a 1:1 in a room without anyone else. he became calm and he stayed in the dining room being fed and removed as soon as he was finished being fed. Review of the Facility Report dated 07/14/21 revealed the following account of the 07/13/21 incident: A resident to resident altercation on 07/13/21 at 04:30 PM and 06:05 PM which involved R84, with a BIMS of four, R47 with a BIMS of six and R71 with a BIMS of six. The report documented on 07/13/21 at approximately 04:30 PM R84 sat in the common area. He went over to R47 and punched her in her side. Witnesses stated R84 was not showing signs of agitation and R47 was sleeping in her chair at that time. Staff separated the residents and redirected R84 to his room. Staff assessed R47 for injuries after the altercation with no injuries found or reported. Staff placed her on 72-hour monitoring for bruising. The report recorded R84 could walk on his own. The report further recorded on 07/13/21 at approximately 06:05 PM R84 was in the dining room for dinner, went over to R71 and started hitting her in the face and chest. R84 was immediately redirected back to his room. Staff assessed R71 for injury with no pain or injury noted. R84 had an order for a urinalysis due to aggressive behaviors. On 08/02/21 at 07:20 AM R84 sat in his wheelchair, in the 200 hallway of Kensington unit, in front the dining area. On 08/03/21 at 07:24 AM R84 sat in his wheelchair in the common area by the nurse's station on the Kensington unit. There were six female residents also seated in the same area. No staff were present, the closest staff member was down the middle hall passing medications, out of the line of sight to view R84. On 08/03/21 at 7:31 AM R84 continued to sit in his wheelchair at the nurse's station with six other female residents. An unidentified staff member pushed another female resident to the common area in a wheelchair, parked the chair, applied the brakes, and walked away. On 08/03/21 at 09:05 AM R84 sat in his wheelchair in the common area by the nurse's station. He lifted his feet in an alternating repetitive motion as if walking. No staff were present in the common area at that time though four other female residents were in the common area with R84. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/04/21 at 07:50 AM R84 was in his new room at the end of the hall on the Serenity unit (a unit adjacent to Kensington unit) with a staff member seated in a chair directly outside his room. On 08/04/21 at 10:02 AM R84 sat in his wheelchair in the dining area on Serenity unit , dressed and covered with a blanket. An unidentified staff member sat with him. On 08/03/21 at 11:20 AM Certified Nurse Aid (CNA) M stated she always worked on the dementia unit. CNA M stated when the CNA knew which residents were at risk for or actually had behaviors by receiving a verbal report during walking rounds at the beginning and end of each shift. The CNA reported to each other any changes, new behaviors, or ongoing concerns. She stated they also checked the Kardex (electronic tool which lists specific cares required by the resident as directed on the care plan or resident task list). She stated the Kardex should tell them everything they need to know to provide care for the residents. CNA M stated she received training when she was hired regarding direct care as well as training on abuse and neglect. She stated abuse, neglect and exploitation was covered frequently in the monthly trainings. CNA M stated that she knew if residents had behaviors, staff should try to figure out the cause of the behaviors. In the event of a resident to resident altercation, they should try to separate the residents and see if the resident could be redirected by coloring books, changing the climate or atmosphere, and adjusting the noise levels. She stated the CNA was to report to the charge nurse if any resident to resident altercation or any new behaviors were identified. She stated some residents would need to be kept separate and staff would know those residents by looking in their Kardex. CNA M said R84 could be combative at times. He typically self-propelled in his wheelchair. She further stated that because R84 had a tendency to use his feet to get himself forward other residents might mistake that for agitation and become afraid. CNA M stated they occasionally had to redirect R84 away from other residents and they would typically use activities or chocolates. CNA stated she could not remember if R84 ever struck another resident, but she was aware staff were to make sure he is not in a certain amount of space of other residents. On 08/03/21 at 11:30 AM CNA N stated she typically worked on the dementia unit. She stated there were many residents on the unit with varying stages of dementia, some were more with it than others. CNA N stated the CNAs learn how to provide care for the residents by looking in their chart. She stated the resident's chart and the Kardex told the CNA everything they need to know to care for the resident including how they transferred, toileted, and if the resident had any behaviors the CNA was to monitor for, and it would also be on the Kardex. She stated any behaviors they observed were reported to the charge nurse. If it was a really big behavior the CNA could put in a new alert in the point of care (POC) documentation which would go to the Director of Nursing (DON), and Assistant Director of Nursing (ADON). She stated if there was a new, big behavior she would definitely chart a new alert for it, but not for their routine, normal behaviors. If they were having a routine behavior CNA N would try to separate the residents, get them in their rooms, and figure out the cause of the behavior. If that did not work, she stated she would get a nurse. She stated she received training on abuse, neglect, and exploitation via the computer training and in-services. CNA N recalled R84 had a history of behaviors and incidents, but not all were his fault. CNA N stated R84 had a habit of thumping his chest and one resident thought he was swinging at her, but he was not. The resident just misunderstood. At that time, staff just removed the other resident and explained to her that R84 was not trying to hit her. CNA N stated she did not think R84 hit anybody though she said he kicked at staff when he was in bed. CNA N stated staff had no specific actions or interventions regarding R84's behaviors that she knew about. She then said if she saw a resident strike another resident she would intervene immediately and then report to the nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/02/21 at 12:00 PM LN H stated there were a lot of behaviors on the dementia unit. She said in the event of resident to resident abuse, she would make sure the area was safe and render any first aid if needed. She said she would make sure both residents were safe, by separating them, and placing them in their rooms or trying redirection. She said if there were specific interventions, it would be listed on the MAR [Medication Administration Record]. LN H said if the situation was significant, she would alert the DON and Administrator. LN H stated R84 had not any recent behaviors that she was aware of. She said she did know he had been physically aggressive towards the staff and other residents at times. LN H stated nursing staff had no special instruction or interventions related to R84's aggressive behaviors. She said any new interventions or changes would be listed in his chart. On 08/02/21 at 02:18 PM Administrative Nurse D stated abuse training had been provided to facility staff frequently this year, at least two or three times, both in-person and via computer training. Administrative Nurse D said R84 had some resident to resident altercations. She stated in those type of situations, she expected staff would separate the residents, assess them for injuries, and look for any identifiable causes. She said after that, staff should keep the involved residents separate from each other and monitor. She further stated the IDT team would review, nursing would make a progress note in the resident's chart each shift and continue to monitor for behaviors. She stated that in the October incident with R84, he was wandering. She stated staff did not generally intervene with wandering for residents on the dementia unit since it was a locked unit. She said if staff noted he had any aggressive behaviors, they would have redirected him back to his room. Administrative Staff D stated R84 became agitated and over-stimulated. Being in his room helped him de-escalate. She stated staff placed him in his room for that purpose, but R84 was able to self-propel himself back to the common areas. Administrative Nurse D said she believed that occurred in July, when the resident struck two other residents. She stated staff placed him in his room, but he brought himself back out, or staff may have brought him out to the dining room since he required assistance with eating. Administrative Nurse D stated she was unable to speculate if any of the resident to resident abuse events could have been prevented although she stated it appeared the interventions and actions taken to prevent abuse in the two instances (October and July) were not entirely effective. The facility policy Abuse: Prevention of and Prohibition Against revised 01/2021 recorded it was the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility would provide oversight and monitoring to ensure that it's staff, who were agents of the facility, delivered care and services in a way that promoted and respected the rights of the residents to be free from abuse and neglect. The policy documented the facility would train staff to understand behavioral symptoms of the residents which increased the risk of abuse which included aggressive reactions of the residents, wandering type behaviors, resistance to care, and outbursts or yelling out. The policy further recorded the facility would take action to protect and prevent abuse and neglect from occurring within the facility. The facility failed to prevent multiple episodes of resident to resident abuse when R84, who had a documented history of aggressive behavior and physical altercation with another resident entered R56's room on 10/21/20 and struck him in the face several times. On 07/13/21, R84 made verbal and physical threats towards another resident and then punched R47 and R71. This deficient practice placed the 37 residents on Kensington, the dementia unit, in immediate jeopardy. The facility removed the immediacy at 10:40 AM on 08/03/21 by completing the following actions: Move R84 to Serenity Unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1:1 with this resident during waking hours with 15 Minute checks during sleeping hours Inpatient referral to be completed on August 4th to find a more appropriate placement for this type of resident with behaviors. IDT completed full audit of all residents on the second floor on August 3, 2021 to determine what residents have the potential to be aggressive and potentially hurt other residents. All residents determined to have the potential to be aggressive or harm residents will have care plan updated, staff informed via jot sheets and the shift change report. Behavioral monitoring audit to be added to the daily clinical meeting. Immediate intervention from staff if there is a resident to resident altercation. Any interaction will need to be reported to DON/ED immediately. All staff will be re-in serviced on this process immediately to be completed by 4:30 pm on Wednesday, August 4th, 2021. Staff will be educated on notifying administration immediately when a resident begins to get upset so that aggression can be avoided, and interventions put in place. - The Diagnoses tab of R21's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, cognitive communication deficit, and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE] documented R21 had a Brief Interview for Mental Status (BIMS) score of six. BIMS scores under seven indicated severe cognitive impairment. R21 had no behaviors during the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/14/21 documented R21 was unable to correctly answer questions during the BIMS interview. The Care Plan dated 01/27/17 documented R21 had dementia and directed staff to administer medications as ordered and monitor/document/report to the medical doctor (MD) any changes in cognitive function. The Care Plan dated 03/19/20, resolved 05/18/21, documented R21 had the potential for lashing out if others got in his space and directed staff to help R21 to maintain safe distance from other residents in common area and to monitor, record, report increased episodes of agitation. The Care Plan dated 03/18/21 documented R21 had the potential to demonstrate physical behaviors related to anger, dementia, and poor impulse control. The Care Plan documented on 03/17/21, R21 grabbed another resident by the left shoulder and bent her forward. The Care Plan directed staff to analyze key times, places, circumstances, triggers, and what escalated behaviors and document. It further directed staff documented observed behavior and attempted interventions, and monitor/document/report to the MD of danger to self and others. The Care Plan directed when R21 became agitated, staff should guide him away from the source of distress and engage R21 calmly in conversation. If his response was aggressive then staff were to walk away calmly and approach later. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Notes tab of R21's EMR revealed a Nursing Note on 03/17/21 at 03:28 PM that documented R21 was in the common area by the nurses' desk. R21 grabbed an unidentified resident by her left shoulder and bent her forward. R21 yelled that she was stealing and stated, if that [expletive] keeps stealing, I'll keep ripping her head off. R21 went to his room and the residents were to stay separated throughout the night. The Notes tab of R15's EMR revealed a Nursing Note on 03/17/21 at 03:31 PM that documented R15 sat in a chair by nurses' desk. Another resident grabbed her by the shoulder and bent her forward. Staff separated the residents and assessed R15's skin. R15 had small amount of redness to the back of the left shoulder. Staffs continued to separate the residents throughout the shift. The Notes tab of R15's EMR revealed a Nursing Note on 03/17/21 at 03:32 PM that documented R15 was involved in resident-to-resident altercation. Another resident grabbed R15 when she took a snack off the other resident's tray and the other resident cussed her out per staff. R15 denied pain upon interview and staff examined her skin. Floor staff educated to keep the residents away from each other. The Notes tab of R21's EMR revealed an Interdisciplinary (IDT) Note on 03/18/21 at 09:57 AM that documented IDT met to discuss an incident of resident to resident altercation on the previous date. R21 grabbed an unidentified resident by the left shoulder and bent her forward. Staff separated the residents. R21 was upset the resident took snacks off his cart. R21 went to his room. Staff were to keep residents separated and if one resident went into the common area, the staff were to redirect the other resident to a separate area. Staff were to monitor the residents at that time. A review of the Facility Report dated 03/20/21 revealed the following account of the 03/17/21 incident: A resident-to-resident altercation on 03/17/21 that involved R21 with a BIMS of five and R15 with a BIMS of three. The report documented R21 was in the common area eating his lunch when R21 came and grabbed his fudge round cookie off his tray. When R15 took the cookie, this made R21 mad, so he grabbed R21 by the shoulder and held her. Staff heard the commotion and removed R21 from the scene. R21 was angry R15 stole the cookie off his tray. Staff redirected R21 to his room. Initial assessment revealed R15 had some light pink fingernail marks from where R21 grabbed her. An order was put in to monitor R21 for behavioral changes. Staff were notified of the situation and advised to redirect R21 back to his room, so the two residents were not near each other. Corrective actions taken in response to the incident included R21 was moved to first floor to keep him separate from residents who wander. A focus in R21's Comprehensive Plan of Care, recorded that on 03/28/21, R21 grabbed another resident by the wrist and started bending her finger backwards. The clinical record lacked further documentation of this resident to resident occurrence on 03/28/21. The facility was unable to provide an investigation for the occurrence on 03/28/21. The Orders tab of R15's EMR documented a Physician Order with a start date of 03/28/21 to monitor her wrist and finger for bruising for any signs/symptoms of injury and to notify the primary care provider as soon as possible for any bruising or any change of condition. The clinical record for R15 lacked documentation for the resident-to-resident altercation on 03/28/21. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/04/21 at 07:30 AM, R21 laid in bed with his eyes closed. He appeared comfortable and without signs or symptoms of distress or discomfort. No behaviors noted. On 08/05/21 at 01:15 PM, R15 sat in a chair in the day room beside another resident. The other resident rested comfortably with her eyes closed in a reclining wheelchair, a weighted blanket laid on top of her lower body. R15 attempted to pull the weighted blanket off the other resident and onto herself. Certified Medication Aide (CMA) R told R15 no and called her a name in Spanish. R15 stopped pulling the blanket off the other resident. R15 appeared comfortable and without signs of distress. 08/03/21 at 11:11 AM, Certified Nurse Aide (CNA) M stated she always worked on the dementia unit. CNA M stated when the CNA knew which residents were at risk for or actually had behaviors by receiving a verbal report during walking rounds at the beginning and end of each shift. The CNA reported to each other any changes, new behaviors, or ongoing concerns. She stated they also checked the Kardex (electronic tool which lists specific cares required by the resident as directed on the care plan or resident task list). She stated the Kardex should tell them everything they need to know to provide care for the residents. CNA M stated she received training when she was hired regarding direct care as well as training on abuse and neglect. She stated abuse, neglect and exploitation was covered frequently in the monthly trainings. CNA M stated that she knew if residents were having behaviors, staff tried to figure out the cause of the behaviors. In the event of a resident to resident altercation, they should try to separate the residents and see if the resident could be redirected by coloring books, changing the climate or atmosphere, and adjusting the noise levels. She stated the CNA was to report to the charge nurse if any resident to resident altercation or any new behaviors were identified. She stated some residents would need to be kept separate and staff would know those residents by looking in their Kardex. She stated a female resident grabbed R21's cookie and he got upset, but she could not recall any other incidents. On 08/03/21 at 11:30 AM CNA N stated she typically worked on the dementia unit. She stated there were many residents on the unit with varying stages of dementia, some were more with it than others. CNA N stated the CNAs learn how to provide care for the residents by looking in their chart. She stated the resident's chart and the Kardex told the CNA everything they need to know on how to care for the resident including how they transferred, toileted, and if the resident had any behaviors. She stated any behaviors they observed were reported to the charge nurse. If it was a really big behavior the CNA could put in a new alert in the point of care (POC) documentation which would go to the Director of Nursing (DON), and Assistant Director of Nursing (ADON). She stated if there was a new, big behavior she would definitely chart a new alert for it, but not for their routine, normal behaviors. If they were having a routine behavior CNA N would try to separate the residents, g [TRUNCATED]

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F 0608 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 100 residents. The sample included 27 residents, with 12 residents reviewed for abuse. Based on observation, record review, and interviews, the facility failed to report to law enforcement a theft of personal property for Resident (R) 149 and R11. This placed the residents at risk for ongoing misappropriation. Findings included: - R149's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia, (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R149 required limited assistance of one staff member for activities of daily living (ADL's). The MDS documented no behaviors for R149. The Quarterly MDS dated [DATE] documented a BIMS score of 99, a staff interview documented she had severely impaired cognition. The MDS documented R149 required extensive assistance of two staff members for ADL's. The MDS documented physical behaviors symptoms directed toward others occurred one to three days during look back period and verbal behavioral symptoms directed toward others occurred four to six days during the look back period. R149's Cognitive Loss Care Area Assessment (CAA) dated 07/22/20 documented she had a short attention span and would pick up items left out, then move those items to another area. R149's Care Pan dated 07/17/20 documented to engage her in simple, structured activities that avoided demanding tasks. Review of Grievance Interview Record form documented on 06/10/21 at 10:50 AM during a scheduled visit with R149, her durable power of attorney (DPOA) noted her rings were missing. The DPOA noted she usually had six rings on her fingers and she only had one ring present at the time of the visit. R149's DPOA reported the missing rings to Social Service X. Social Services X searched R149's room and was unable to find any other rings. Social Services X informed R149's DPOA the facility would investigate, but it would be hard to determine because of the frequent hospital admissions. Review of R149's EMR under the Misc tab revealed a scanned inventory sheet that lacked a date and signature. The inventory documented six rings present. The facility was unable to provide evidence law enforcement was notified by the facilty of the allegation of theft for R149. (continued on next page)

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	175298	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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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 0608 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/21 at 08:45 AM in an interview, Social Services X stated that the investigation was still ongoing for the missing rings for R149. Social Services X stated that the facility had just purchased a camera in the last 30 days for the social service department to photograph resident's items of value. Social Services X stated that the nursing staff would inventory items upon admission and then the social service department would complete a more detailed inventory and label clothing after 24 hours. Social Services X stated that she did not believe that the law enforcement had been notified of the missing rings. On 08/05/21 at 11:05 AM in an interview, Certified Nurse Aide (CNA) O stated if any personal property was missing, staff fill out a sheet for the social services designee (SSD). CNA O stated the staff check the resident's room and check in the laundry for the missing items. CNA O stated that the social service department complete the resident's inventory on admission to the facility. On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated the SSD is notified of the missing item, then she interviews the resident and/or family. Staff check the resident's room and the laundry for the missing items. On 08/05/21 at 04:58 PM in an interview, Administrative Staff A stated the missing rings for R149 was still under investigation. Administrative Staff A stated law enforcement was not notified of the missing rings. Administrative Staff A stated that grievance would change to a misappropriation of funds if a resolution could not be found. Administrative Staff A stated that she would be person that would notify the law enforcement department. The facility Abuse: Prevention of and Prohibition Against policy dated January 2021 document all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable time frames. The facility failed to protect and report a suspicion of theft for R149, which put her a risk for ongoing abuse or misappropriation. - R11's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), psychosis (any major mental disorder characterized by a gross impairment testing), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 required extensive assistance of two staff members for Activities of Daily Living (ADL's). The MDS documented R11 required physical assistance of one staff member for bathing during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R11 was totally dependent of one staff member for ADL's and bathing during the look back period. R11's Cognitive Loss Care Area Assessment (CAA) dated 11/17/20 documented she was alert and oriented with some confusion. (continued on next page)

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F 0608 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Care Pan dated 11/12/20 documented staff would converse with her when they provided care. Review of the Grievance Interview Record form dated 01/07/21 documented the family reported that R11's wedding ring was missing. R11's room was searched, all drawers, pockets, shower room, bathroom, nurses cart and nurses drawers. Social Service staff Y documented that staff were interviewed and reported that no staff had seen the ring when R11 was admitted to the facility on [DATE]. The facility was unable to provide evidence law enforcement was notified of the allegation of misappropriation for R11. On 08/05/21 at 08:45 AM in an interview, Social Services X stated that the investigation was still ongoing for the missing rings for R149. Social Services X stated that the facility had just purchased a camera in the last 30 days for the social service department to photograph resident's items of value. Social Services X stated that the nursing staff would inventory items upon admission and then the social service department would complete a more detailed inventory and label clothing after 24 hours. On 08/05/21 at 04:58 PM in an interview, Administrative Staff A stated the missing rings for R11 was still under investigation. Administrative Staff A stated law enforcement was not notified of the missing ring. Administrative Staff A stated that grievance would change to a misappropriation of funds if a resolution could not be found. Administrative Staff A stated that she would be person that would notify the law enforcement department. Administrative Staff A stated she was unable to locate an inventory for R11. The facility Abuse: Prevention of and Prohibition Against policy dated January 2021 document all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable time frames. The facility failed to report a suspicion of theft/misappropriation R11, which put her a risk for ongoing abuse or misappropriation.

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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** 42966 The facility identified a census of 100. The sample included 27 residents with 12 reviewed for abuse, neglect and exploitation. Based on record review, observation and interview, the facility failed to report to the State Agency (SA), allegations, occurrences, and/or suspicions of resident-to-resident abuse for Resident(R) 21 and R15. The facility failed to report, within the 24-hour mandated timeframe, an occurrence of neglect for R148 and failed to report two allegations of misappropriation, for R149 and R11. This deficient practice placed the residents at risk for unresolved and ongoing abuse, neglect, and misappropriation. Findings included: - The Diagnoses tab of R21's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, cognitive communication deficit, and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE] documented R21 had a Brief Interview for Mental Status (BIMS) score of six which indicated severe cognitive impairment. R21 had no behaviors during the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/14/21 documented R21 was unable to correctly answer questions during the BIMS interview. The Care Plan dated 01/27/17 documented R21 had dementia and directed staff to administer medications as ordered and monitor/document/report to medical doctor (MD) any changes in cognitive function. The Care Plan dated 03/19/20, resolved 05/18/21, documented R21 had the potential for lashing out if others got in his space and directed staff to help R21 to maintain safe distance from other residents in common area and to monitor, record, report increased episodes of agitation. The Care Plan dated 03/18/21 documented R21 had the potential to demonstrate physical behaviors related to anger, dementia, and poor impulse control. The Care Plan documented on 03/17/21, R21 grabbed another resident by the left shoulder and bent her forward. The Care Plan directed staff analyzed key times, places, circumstances, triggers, and what escalated behavior and documented. It further directed staff documented observed behavior and attempted interventions and monitored/documented/reported to MD of danger to self and others. The Care Plan directed when R21 became agitated, staff guided him away from source of distress and engaged R21 calmly in conversation, if his response was aggressive then staff were to walk away calmly and approach later. A focus in R21's comprehensive plan of care, recorded that on 03/28/21, R21 grabbed another resident by the wrist and started bending her finger backwards. The clinical record lacked further documentation of this resident-to-resident occurrence on 03/28/21. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Orders tab of R15's EMR documented an order with a start date of 03/28/21 to monitor wrist and finger for bruising for any signs/symptoms of injury and to notify primary care provider as soon as possible for any bruising or any change of condition. The clinical record for R15 lacked documentation for the resident-to-resident altercation on 03/28/21. On 08/04/21 at 07:30 AM, R21 laid in bed with his eyes closed. He appeared comfortable and without signs or symptoms of distress or discomfort. No behaviors noted. On 08/05/21 at 01:15 PM, R15 sat in chair in day room beside another resident. The other resident rested comfortably with her eyes closed in a reclining wheelchair, a weighted blanket laid on top of her lower body. R15 attempted to pull the weighted blanket off the other resident and onto herself. Certified Medication Aide (CMA) R told R15 no and called her a name in Spanish. R15 stopped pulling the blanket off the other resident. R15 appeared comfortable and without signs of distress. 08/03/21 at 11:11 AM, Certified Nurse Aide (CNA) M stated she had worked in the facility for about one year. She always worked on the dementia unit. According to CNA M, the dementia unit (Kensington) was used to house residents who were at risk for elopement (when a cognitively impaired resident leaves the facility without staff knowledge). She stated the CNA was to report to the charge nurse if any resident to resident altercation or any new behaviors were identified. She stated some residents would need to be kept separate and staff would know those residents by looking in their Kardex. She stated a female resident grabbed R21's cookie and he got upset but she could not recall any other incidents. On 08/03/21 at 11:30 AM CNA N stated she had recently returned to the facility full time but had been there intermittently through agency from last November to March of this year. She stated she typically worked on the dementia unit. She stated there were many residents on the unit with varying stages of dementia, some were more with it than others. She stated any behaviors they observed were reported to the charge nurse. If it was a really big behavior the CNA could put in a new alert in the point of care (POC) documentation which would go to the Director of Nursing (DON) and Assistant Director of Nursing (ADON). She stated R15 tried to grab a cookie off his tray and R21 tried to bend her finger backwards. He needed to be taken to his room and had to stay in his room that night. On 08/02/21 at 12:00 PM Licensed Nurse (LN) H stated she had worked in the facility on and off for several years. She stated she had done most training in the computer system and received reports of any in-service she may have missed. She stated the facility's abuse coordinator was the administrator. LN H stated there were a lot of behaviors on the dementia unit. LN H said if the situation was significant, she would alert the Director of Nursing (DON) and Administrator. She stated she had heard R21 hit someone, but she had not been in the facility when he did anything. On 08/02/21 at 02:18 PM Administrative Nurse D stated abuse training had been provided to facility staff frequently this year, at least two or three times, both in-person and via computer training. Administrative Staff D stated the facility Abuse Coordinator was Administrative Staff A. She stated it appeared as though the resident-to-resident incident in question occurred on 03/26/21 but did not get put on the care plan until 03/28/21. On 08/03/21 at 03:37 PM, Administrative Staff A stated the incident on 03/28/21 with R21 involved R15 as well and was not reported to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Abuse: Prevention of and Prohibition Against revised 01/2021 recorded it was the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy directed facility staff were trained on reporting abuse, neglect, exploitation, and misappropriation of resident property including injuries of unknown sources and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal. The policy directed all allegations of abuse, neglect, misappropriation of resident property, or exploitation were reported immediately to the Administrator and allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State agencies in the applicable timeframes. The facility failed to report to the SA, allegations, occurrences, and/or suspicions of resident-to-resident abuse for Resident(R) 21 and R15 on 03/28/21. This deficient practice placed the residents at risk for unresolved and ongoing abuse and neglect. 40688 - R148's diagnoses, listed under the Diagnosis tab in the electronic medical record (EMR), included dementia (progressive mental disorder characterized by failing memory, confusion), repeated falls, need for assistance with personal cares and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) without pathological fracture (a broken bone that's caused by a disease, rather than an injury). The Annual Minimum Data Set (MDS) dated [DATE] recorded R148 had a Brief interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. She had occasional rejection of cares. R148 required limited assistance of one staff for bed mobility, dressing, toileting and personal hygiene. She required supervision of one staff member for transfers, and walking using a walker. She had one non-injury fall since the last assessment. The Cognitive Loss Care Area assessment dated [DATE] recorded R148 had an alteration in cognition. The Quarterly MDS dated [DATE] documented R148 had severe cognitive impairment with a BIMS score of three and no behaviors. She required supervision of one staff member for walking with a walker and limited assistance of one staff member for transfers, bed mobility, and toileting. The MDS recorded she had two or more non-injury falls since the last assessment on 06/29/20. The Care Plan dated 06/03/19 and revised/resolved on 01/20/21 listed a focus which documented R148 had an actual fall with injury(non-major) due to poor balance and unsteady gait. The focus further recorded listed the following falls: Fall 5/31/2019, Fall 8/15/2019 Skin tear, Fall 12/2/2019, Fall 12/3/2019, Fall 03/01/2020, Fall 4/4/2020, Fall 4/11/2020, Fall 6/24/2020, Fall 7/2/2020, Fall 11/14/2020 - sent to [hospital], Fall 12/26/20. The Care Plan listed an intervention dated 05/05/20 which documented the interdisciplinary team (IDT) fall care team met to discuss R148's fall on 4/11/20. The intervention documented staff stated at 12:30 AM a nurse aid reported R148 was lying on the floor. The nurse entered R148's room and observed her on the floor on top of the bed sheet and blanket. This intervention was resolved on 06/29/20. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan recorded a specific intervention, initiated on 05/20/20 which directed staff R148 required hourly checks when she was in her room. This intervention was resolved on 11/16/20, after R148's fall on 11/14/20. Review of the Progress Notes tab in R148's EMR revealed the following notes: A Nursing Note dated 11/14/20 at 07:13 AM authored by Licensed Nurse (LN) I recorded at 05:15 AM an unidentified Certified Nurse Aid (CNA) notified LN I R148 laid on her bed bleeding. LN I entered R148's room and observed R148 on the bed, without her clothing, and feces smeared all over and on the floor. R148's walker was away from her and her nonskid socks were removed. Neurological checks were performed by LN I, R148 was able to move all extremities and followed simple commands but only mumbled words. LN I documented R148 had an open area and dry blood on the left side of her head and a big hematoma (an injury causing blood to collect and pool under the skin) and minor skin tears on her left outer forearm. LN I and the unidentified CNA cleaned R148. LN I documented the last time R148 was seen by nursing was 03:00 AM. LN I notified Consultant II, R148's durable power of attorney (DPOA) and Administrative Nurse E. R148 left the faciity on a stretcher at 06:15 AM. A Fall Committee IDT Note dated 11/15/20 at 11:54 AM authored by Administrative Nurse D recorded the IDT met to discuss R148's fall on 11/14/20. At 05:15 AM, the unidentified CNA notified LN I R148 laid on her bed bleeding. Upon entering the room LN I observed R148 lying on the bed, without her clothing. Feces smears were noted on the floor. R148's walker was not within reach and nonskid socks were not on. A head to toe assessment was completed and neurological checks initiated. R148 was able to move all extremities and follow simple commands. R148 had an open area and dry blood on the left side of her head. She also had a large hematoma and minor skin tears to her left outer forearm. R148 was last observed in bed with no injuries at 03:00 AM. The note recorded a root cause analysis as resident taking self to the bathroom and fell and documented an intervention of PT/OT [physical therapy/occupational therapy] to screen for transfer and ambulation techniques. Staff to offer toileting every two hours. The undated unsigned Facility Investigation documented the following: On 11/14/2020 at approximately 5:00am, the CNA went to check on [R148]. The resident was in her bed and was noted to have blood from a skin tear and a large hematoma on her left arm. She also had BM [bowel movement] smeared on her legs and on the floor. The nurse was called into the room and assessed the resident. At this time, all of her limbs were moved without difficulty. The nurse noted an open area with blood on the left side of her head. The doctor was called and asked that the resident be sent to the ER [emergency room] to be examined. The hospital called [the facility] to say that the resident was going to be admitted but gave no diagnosis. Today (11/17/2020), the residents son called and stated that his mom had just had surgery this morning for a fractured left hip. [The facility] had not been informed and therefore we are just reporting this injury now. [R148] is confused but does get up and walk alone with her walker. It appears that she got up and attempted to use the bathroom but fell and was able to get back into bed. Staff [have] been interviewed and there does not appear to be any abuse/neglect involved. The last time the CNA was in the room was around 3:00am and stated resident was covered up and asleep. IDT had met after this fall and agreed to have PT/OT work with resident on transfer/ambulation techniques. Residents fall risk is a 13 - high risk and has been on the facility falling star program which involves several interventions to prevent falls. Resident will be readmitted to [the facility] post-surgery. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R148's EMR, under the Misc. tab, contained a scanned document titled [R148) _Hospital_Updates_11-16-20. Page one, the fax cover sheet, recorded a date of Monday, November 16, 2020 08;43 AM. The fax timestamp at the top of the page was 11/16/20 08:44:02 AM. The fax was sent to the facility from Department of Case Management at the hospital. Page seven of the document recorded a Trauma History and Physical which recorded R148 was a trauma consult after a fall sustaining a chronic subdural hematoma (collection of blood on the surface of the brain), left scalp contusion (injured tissue or skin), displaced acetabulum fracture, left elbow skin tear left retroperitoneal hematoma (accumulation of blood in the area in the back of the abdomen, typically from blunt trauma). The note recorded per R148's chart she was a t a care facility when she was found out of bed at approximately 05:15 AM. On 08/05/12 at 12;30 PM Administrative Nurse E stated she received abuse training all the time, normally at the monthly in-service and randomly through the months. Administrative Nurse E stated she notified Administrative Nurse D of any allegation of abuse or neglect. Administrative Nurse E stated she remembered the 11/14/20 incident with R148. Administrative Nurse E stated staff did not follow R148s plan of care when they failed to check her hourly as directed. She confirmed Administrative Staff E was the facility Abuse Coordinator and responsible for reporting incidents and allegations of abuse and neglect. On 08/05/21 at 03; 49 PM Administrative Nurse D stated she remembered R148's 11/14/20 fall. She stated the investigation concluded R148 fell taking herself to the bathroom since there was BM on the resident, the surrounding area and in the commode. She stated R148 had the capability of getting herself off the floor and back in bed. She confirmed staff failed to provide the hourly checks as required in R148s plan of care since they checked her at 03:00 AM and not again until 05:15 AM and that failure may have been contributory to the event which led to R148's injuries. Administrative Nurse D stated Administrative Staff E was the facility's Abuse Coordinator and responsible for reporting allegations and incidents of abuse to the SA. The facility policy Abuse: Prevention of and Prohibition Against revised 01/2021 recorded it was the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility would provide oversight and monitoring to ensure that it's staff, who were agents of the facility, delivered care and services in a way that promoted and respected the rights of the residents to be free from abuse and neglect. The policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish nor emotional distress. The policy further directed all allegations of abuse, neglect and misappropriation would be reported outside of the facility and to the appropriate state or federal agencies in the applicable time frames per the policy and applicable regulations. The facility failed to report an instance of neglect, within the mandated 24-hour timeframe, when the facility waited until three days after the occurrence to report the occurrence to the SA. This deficient practice placed R148 at risk for unresolved and ongoing neglect. 41037 - R149's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia, (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R149 required limited assistance of one staff member for activities of daily living (ADL's). The MDS documented no behaviors for R149. The Quarterly MDS dated [DATE] documented a BIMS score of 99, a staff interview documented she had severely impaired cognition. The MDS documented R149 required extensive assistance of two staff members for ADL's. The MDS documented physical behaviors symptoms directed toward others occurred one to three days during look back period and verbal behavioral symptoms directed toward others occurred four to six days during the look back period. R149's Cognitive Loss Care Area Assessment (CAA) dated 07/22/20 documented she had a short attention span and would pick up items left out, then move those items to another area. R149's Care Pan dated 07/17/20 documented to engage her in simple, structured activities that avoided demanding tasks. Review of Grievance Interview Record form documented on 06/10/21 at 10:50 AM during a scheduled visit with R149, her durable power of attorney (DPOA) noted her rings were missing. The DPOA noted she usually had six rings on her fingers and she only had one ring present at the time of the visit. R149's DPOA reported the missing rings to Social Service X. Social Services X searched R149's room and was unable to find any other rings. Social Services X informed R149's DPOA the facility would investigate, but it would be hard to determine because of the frequent hospital admissions. Review of R149's EMR under the Misc tab revealed a scanned inventory sheet that lacked a date and signature. The inventory documented six rings present. The facility was unable to provide evidence the allegation of misappropriation was reported to the state agency. On 08/05/21 at 08:45 AM in an interview, Social Services X stated that the investigation was still ongoing for the missing rings for R149. Social Services X stated that the facility had just purchased a camera in the last 30 days for the social service department to photograph resident's items of value. Social Services X stated that the nursing staff would inventory items upon admission and then the social service department would complete a more detailed inventory and label clothing after 24 hours. On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated the Social Service Director notified of the missing item, then she interviews the resident and/or family. Staff check the resident's room and the laundry for the missing items. On 08/05/21 at 04:58 PM in an interview, Administrative Staff A stated the missing rings for R149 was still under investigation. Administrative Staff A stated law enforcement was not notified of the missing rings. Administrative Staff A stated that grievance regarding lost items would change to an allegation of misappropriation if a resolution could not be found. Administrative Staff A stated that she would be person that would notify the State Agency. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse: Prevention of and Prohibition Against policy dated January 2021 document all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable time frames. The facility failed to report the allegation of misappropriation for R149 within the required amount of time which put her a risk for ongoing abuse or misappropriation of personal items. - R11's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), psychosis (any major mental disorder characterized by a gross impairment testing), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 required extensive assistance of two staff members for Activities of Daily Living (ADL's). The MDS documented R11 required physical assistance of one staff member for bathing during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R11 was totally dependent of one staff member for ADL's and bathing during the look back period. R11's Cognitive Loss Care Area Assessment (CAA) dated 11/17/20 documented she was alert and oriented with some confusion. R11's Care Pan dated 11/12/20 documented staff would converse with her when they provided care. Review of the Grievance Interview Record form dated 01/07/21 documented the family reported that R11's wedding ring was missing. R11's room was searched, all drawers, pockets, shower room, bathroom, nurses' cart and nurses' drawers. Social Service staff Y documented that staff were interviewed and reported that no staff had seen the ring when R11 was admitted to the facility on [DATE]. On 08/05/21 at 08:45 AM in an interview, Social Services X stated that the investigation was still ongoing for the missing rings for R149. Social Services X stated that the facility had just purchased a camera in the last 30 days for the social service department to photograph resident's items of value. Social Services X stated that the nursing staff would inventory items upon admission and then the social service department would complete a more detailed inventory and label clothing after 24 hours. On 08/05/21 at 04:58 PM in an interview, Administrative Staff A stated the missing rings for R11 was still under investigation. Administrative Staff A stated law enforcement was not notified of the missing ring. Administrative Staff A stated that grievance would change to a misappropriation of funds if a resolution could not be found. Administrative Staff A stated that she would be person that would notify the law enforcement department. Administrative Staff A stated she was unable to locate an inventory for R11. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse: Prevention of and Prohibition Against policy dated January 2021 document all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable time frames. The facility failed to report the allegation of misappropriation for R11 within the required amount of time which put her a risk for ongoing abuse or misappropriation of personal items.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40688 The facility identified a census of 100. The sample included 27 residents with 12 residents reviewed for abuse. Based on record review, observation, and interviews, the facility failed to protect 37 residents on the Kensington unit (secured dementia unit) from abuse and neglect while investigating episodes and/or allegations of abuse and neglect. The facility further failed to fully investigate, identify, and implement interventions in response to instances of resident to resident abuse. Resident (R) 84, who had a history of aggressive behaviors and striking another resident on 10/20/21 entered R56's room on 10/21/20 and struck him in the face multiple times. On another occasion, R84 acted aggressively. Staff failed to implement an immediate intervention, subsequently R84 punched R47. Again, staff failed to implement measures aimed to protect residents and approximately two hours later, R84 hit R71. The facility further failed to implement protective interventions when R21, who had a history of aggressive behaviors grabbed R15 and bent her over, and then later R21 again grabbed R15, by the wrist and attempted to bend her fingers back. The facility's failure to protect residents from resident to resident abuse placed residents on the dementia unit in immediate jeopardy. Further, the facility failed to fully investigate and identify an episode of neglect when the facility failed to complete a thorough investigation and identify the facility's failure to provide the necessary care as defined in the comprehensive plan for care for R148. R148, who had a history of falls, was required to have hourly checks when in her room alone. The facility failed to provide the hourly check and during the time unattended, R148 obtained injuries consistent with a fall which included an acetabular fracture (pelvis fracture involving the hip joint). The facility reviewed the occurrence, placed interventions for a fall but did not address the neglect which occurred when staff failed to provide the necessary hourly checks for R148. This placed R148 at risk for continued neglect . Findings include: - R84's diagnoses, listed under the Diagnosis tab in the electronic medical record (EMR), included dementia with Lewy bodies (a progressive mental disorder characterized by failing memory, and confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and impulse disorder (a condition in which a person has trouble controlling emotions or behaviors). R84's Admission Minimum Data Set (MDS) on 04/12/21 recorded R84 had a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS recorded he wandered one to three days of the look back period, which was improved from his prior assessment. The 04/12/21 Behaviors Symptoms Care Area Assessment indicated R84's behaviors would be addressed in the plan of care. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Quarterly MDS dated [DATE] recorded R84's BIMS remained four. The MDS recorded R84 received limited assistance of one staff for locomotion on the unit in a wheelchair. The MDS documented R84 had behaviors which included physical behavioral symptoms directed towards other (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) for one to three days of the look back period. R84 had verbal behavioral symptoms directed at others (e.g. threatening, screaming, cursing) for one to three days of the look back period. Sections 0500 and 0600 of the MDS which addressed the impact R84's behaviors had on himself and other residents was not completed. R84's Care Plan, in the EMR under the Care Plan tab, documented a focus dated 10/20/20 and revised on 07/14/21 which recorded R84 had actual physical behaviors (yelling, hitting) due to his dementia, schizophrenia, bipolar disorder, anger, depression, and poor impulse control. He had a history of harm to others. The focus also recorded resident to resident 10/20/20 resident to resident 10/21/20 resident to resident 07/13/21. The Care Plan interventions dated 10/21/20 directed staff to analyze key times, places and triggers as well as what de-escalated the behaviors and document. It directed staff to assess and address for contributing sensory deficits, assess and anticipate the resident's needs: food, thirst, toileting needs, comfort level, body positioning, and pain. The Care Plan directed to document observed behavior and attempted interventions and directed staff to guide R84 away from sources of distress, engage him calmly in conversation. The Care Plan directed staff to walk calmly away, and approach later if R84's response to staff was aggressive. The Care Plan and clinical record lacked specific interventions or evidence measures were implemented and communicated to staff after the 10/20/20 incident. The Care Plan also documented the following interventions dated 10/21/21: Resident to resident 10/20/20. Resident [R84] went into another resident's room and hit [the] resident in the eye. Resident [R84] redirected back to his room and given snacks. Resident to resident 10/21/20. Resident [R84] went into another resident's room and started hitting [the] resident. Resident [R84] redirected to common area. Resident [R84] sitting with a one on one and plan to send resident [R84] to [hospital] for evaluation. Other interventions dated 07/13/21 recorded Resident to resident 7/13/2021: Psychiatrist gave order for UA [urinalysis] and referral to [psychiatric hospital] for potential admission and change of condition for increased behaviors, aggressiveness towards other staff. The Care Plan and clinical record lacked evidence resident-specific interventions were implemented and communicated to staff to prevent further episodes of abuse. The Progress Notes tab in R84's EMR recorded the following notes: A Nursing Note dated 10/20/20 at 02:06 PM which recorded an unidentified Certified Medication Aid (CMA) and social worker alerted License Nurse (LN) G R84 went into another unidentified resident's room and hit him the eye. LN G documented R84 was observed wandering approximately 10 minutes prior to the incident but had demonstrated no aggressive behaviors. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A IDT (interdisciplinary) Note dated 10/21/20 at 07:00AM authored by Administrative Nurse D recorded the IDT team met to discuss the altercation. CMA and social worker notified LNG R84 went to another resident's room and hit him, R84 was noted wandering in the common area approximately 10 minutes prior to the incident. R84 had no aggression noted after the incident. R84 was easily redirected to his room and offered snacks and supervision to ensure he stayed in his room. The note recorded an intervention of resident redirected to room and offered supervision with no signs of aggression or agitation noted. A Social Service Summary dated 10/21/20 at 09:00 AM authored by Social Services X documented R84 was a pleasant male with Lewy body dementia, admitted to the facility for long term care following a hospitalization . The note recorded R84 was previously at a long-term care facility, but he became agitated nad combative with another resident and could not return there. A Nursing Note dated 10/21/20 at 03:50 PM authored by LN G documented R84 sat in the common area when he began to wander off the unit. Staff attempted to redirect R84 and he got upset and made repetitive aggressive statement. R84 then went into [R56's] room and began to hit R56 in his face while he laid in bed. R56 yelled out NO repeatedly. R84 then left R56's room with the unidentified social worker and sat in the common area. R84's representative was contacted and gave permission for R84 to be sent to the hospital in necessary. The (unidentified) physician was notified and the physician gave the order to transfer as needed. R84 was one to one observation. An IDT Note dated 10/21/20 at 04:37 PM authored by Administrative Nurse D recorded the IDT met to discuss the incident that occurred on 10/21/21. R84 sat in the common area where he began to wander on the unit. Staff attempted to redirect him, and he became upset, and made aggressive statements. He then entered [R56's] room and began to hit R56 in the face while R56 laid in bed. R84 exited R56's room with a (unidentified) social worker and was redirected to sit in the common area. The note documented an intervention of R84 to be one to one observation and sent to the hospital for evaluation. A Nursing Note on 10/21/20 at 06:33 PM recorded R84 was transferred to the hospital. A Nursing Note dated 10/22/20 at 02:15 AM recorded R84 returned to the facility from the hospital with a diagnosis of a urinary tract infection and orders for an antibiotic (medication used to treat bacterial infections). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Facility Report dated 10/22/20 revealed the following account of the 10/21/20 incident: on 10/21/2020 at 03:45 PM a resident to resident altercation occurred between R84, who had aa BIMS of 99 (unable to complete interview) and R56 who had a BIMS of six (severe cognitive impairment). Both residents resided on the locked memory care unit. On 10/21/20, R84 was observed beginning to wander on the unit. Staff members attempted to redirect R84 and he began to get upset, made aggressive repetitive statements. R84 then went into R56 ' s room and began to hit R56 in his face while R56 was lying in bed. R56 was yelling out No, no, No. The incident was witnessed by the social worker who was attempting to redirect R84. R56 did attempt to defend himself by putting his left arm over his face. R84 then came out of the room with the social worker. R84 was redirected to the common area where he appeared calm with no agitation or aggression noted. Staff immediately initiated 1:1 constant supervision of R84. Consultant HH was notified and orders given to transfer to the hospital of choice for evaluation. R84's durable power of attorney (DPOA) was notified and in agreement with sending to emergency department for evaluation. R56 had two small scratches noted to his left forearm. No bruising or discoloration to face currently. R84 was unable to give a statement of why he struck R56. R84 did not answer any questions related to incident. Further review of Progress Notes tab in R84's EMR revealed the following: A Nursing Note dated 10/27/20 at 10:00 PM authored by LN H recorded R84 wandered and talked to himself. Staff closely monitored him and when attempted to redirect him. R84 became agitated and swung at staff. LN L attempted to redirect R84 three times with the same result. R84 went into another resident's room and laid in that resident's bed. When staff attempted to assist R84 to his room, R84 screamed and threatened staff. Staff notified Consultant HH and received an order for Haldol (antipsychotic medicine that is used to treat schizophrenia) every eight hours as needed. An injection of Haldol was administered to R84. LN L obtained a (unidentified) male nurse to assist R84 to his room. A Nursing Note' dated 07/13/21 at 03:00 PM authored by LN K recorded R84 sat in the common area when another (unidentified) male resident attempted to pass by. R84 told the other resident R84 was going to kill him. Both residents yelled at each other. R84 made a fist and lifted his hand to hit the other resident. LN K intervened and quickly moved the other resident. Both residents were angry. LN K explained to both residents that their behavior was inappropriate. R84 responded with cold, cold it's cold. R84 was alert but oriented to his name only. At approximately 06:00 PM LN K heard R84, in the hallway coming back from the dining room, threaten someone. LN K ran over to see what was going on and saw R84 threaten a (unidentified) female resident. He attempted to hit her and missed. LN K again removed R84 from area and placed him in front of his room. At 06:05 PM R84 propelled himself to the common area and hit another (unidentified) resident in the face and chest with his fist. LN K again removed R84 and contacted the psych nurse NP [nurse practitioner] who gave new orders. The note documented Administrative Nurse E was notified after immediately after each incident. A Nursing Note dated 07/13/21 at 04:09 PM authored by LNK recorded the following At 4pm this writer observed resident [R84]sitting in his w/c [wheelchair] next to this writer when resident reached over and socked a female resident who was sitting in a chair next to him asleep, he hit her with his fist saying do you want to die. this writer removed the resident with a 1:1 in a room without anyone else. he became calm and he stayed in the dining room being fed and removed as soon as he was finished being fed. A Nursing Note dated 07/14/21 at 04:21 PM authored by LN K repeated the same note as documented by LN K on 07/13/21 at 03:00PM. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Facility Report dated 07/14/21 revealed the following account of the 07/13/21 incident: A resident to resident altercation on 07/13/21 at 04:30 PM and 06:05 PM which involved R84, with a BIMS of four, R47 with a BIMS of six and R71 with a BIMS of six. The report documented on 07/13/21 at approximately 04:30 PM R84 sat in the common area. He went over to R47 and punched her in her side. Witnesses stated R84 was not showing signs of agitation and R47 was sleeping in her chair at that time. The residents were separated, and R84 was redirected to his room. R47 was assessed for injuries after the altercation with no injuries found or reported. She was placed on 72-hour monitoring for bruising. The report recorded R84 could walk on his own. The report further recorded on 07/13/21 at approximately 06:05 PM R84 was in the dining room for dinner, went over to R71 and started hitting her in the face and chest. R84 was immediately redirected back to his room. R71 was assessed for injury with no pain or injury noted. R84 had an order for a urinalysis due to aggressive behaviors. On 08/02/21 at 07:20 AM R84 sat in his wheelchair, in the 200 hallway of Kensington unit, in front the dining area. On 08/03/21 at 07:24 AM R84 sat in his wheelchair in the common area by the nurse's station on the Kensington unit. There were six female residents also seated in the same area. No staff were present, the closest staff member was down the middle hall passing medications, out of the line of sight to view R84. On 08/03/21 at 7:31 AM R84 continued to sit in his wheelchair at the nurse's station on the Kensington unit with six other female residents. An unidentified staff member pushed another female resident to the common area in a wheelchair, parked the chair, applied the brakes and walked away. On 08/03/21 at 09:05 AM R84 sat in his wheelchair in the common area by the nurse's station on Kensington unit. He lifted his feet in an alternating repetitive motion as if walking. No staff were present in the common area at that time though four other female residents were in the common area with R84. On 08/04/21 at 07:50 AM R84 was in his new room at the end of the hall on the Serenity unit (another unit in the facility adjacent to Kensington unit) with a staff member seated in a chair directly outside his room. On 08/04/21 at 10:02 AM R84 sat in his wheelchair in the dining area on Serenity unit , dressed and covered with a blanket. An unidentified staff member sat with him. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/03/21 at 11:20 AM Certified Nurse Aid (CNA) M stated the CNA knew which residents were at risk for or actually had behaviors by receiving a verbal report during walking rounds at the beginning and end of each shift. The CNA reported to each other any changes, new behaviors or ongoing concerns. She stated they also check the Kardex (electronic tool which lists specific cares required by the resident as directed on the care plan or resident task list). She stated the Kardex should tell them everything they need to know to provide care for the residents. CNA M stated that she was knew if resident were having behaviors, staff should try to figure out what the cause of the behaviors was. In the event of a resident to resident altercation, they should try to separate the residents and see if the resident could be redirected by coloring books, changing the climate or atmosphere and adjusting the noise levels. She stated the CNA was to report to the charge nurse if any resident to resident altercation or any new behaviors were identified. She stated some residents would need to be kept separate and staff would know those residents by looking in their Kardex. CNA M said R84 could be combative at time. He typically self-propelled in his wheelchair. She further stated that because R84 had a tendency to use his feet to get himself forward other residents might mistake that for agitation and become afraid. CNA M stated they occasionally had to redirect R84 away from other residents and they would typically use activities, or chocolates. CNa stated she could not remember if R84 had ever struck another resident, but she was aware staff were to make sure he is not in a certain amount of space of other residents. On 08/03/21 at 11:30 AM CNA N there were many residents on the unit with varying stages of dementia, some were more with it than others. CNA N stated the CNAs learn how to provide care for the appropriate cares to the residents by looking in their chart. She stated the resident's chart, the Kardex, told the CNA everything they need to know on how to care for the resident including how they transferred and toileted and if the resident had any behaviors the CNA was to monitor for, it would also be on the Kardex. CNA N tried to separate the residents, get them in their rooms, and figure out the cause of the behavior. If that did not work, she stated she would get a nurse. She stated she had received training on abuse, neglect and exploitation via the computer training and in-services. CNA N recalled R84 had a history of behaviors and incidents but not all were his fault. CNA N stated R84 had a habit of thumping his chest and one resident thought he was swinging at her but he was not. The resident just misunderstood. At that time, staff just removed the other resident and explained to her that R84 was not trying to hit her. CNA N stated she did not think R84 had hit anybody though she said he had kicked at staff when he was in bed. CNA N stated staff had no specific actions or interventions regarding R84's behaviors that she knew about. He then said if she saw a resident strike another resident she would intervene immediately and then report to the nurse. On 08/02/21 at 12:00 PM LN H stated there were a lot of behaviors on the dementia unit. She said in the event of resident to resident abuse, she would make sure the area was safe and render any first aid if needed. She said she would make sure both residents were safe, by separating them and placing them in their rooms or trying redirection. She said if there were specific interventions nursing was required to do, it would be listed on the MAR [Medication Administration Record]. LN H said if the situation was significant, she would alert the DON and Administrator. LN H stated R84 had not any recent behaviors that she was aware of. She said she did know he had been very physically aggressive towards the staff and other residents at times. LN H stated nursing staff had no special instruction or interventions related to R84's aggressive behaviors. She said any new interventions or changes would be listed in his chart. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/02/21 at 02:18 PM Administrative Nurse D stated abuse training had been provided to facility staff frequently this year, at least two or three times, both in-person and via computer training. Administrative Nurse D said R84 had some resident to resident altercations. She stated in those type of situations, she expected staff would separate the residents and assess them for injury and look for any identifiable causes. She said after that, staff should keep the involved residents separate from each other and monitor. She further stated the IDT team would review, nursing would make a progress note in the resident's chart each shift and continue to monitor for behaviors. She stated that in the October incident with R84, he had been noted wandering. She stated staff did not generally intervene with wandering for residents on the dementia unit since it was a locked unit. She said if staff had noted him with any aggressive behaviors, they would have redirected him back to his room. Administrative Staff D stated R84 gets agitated and over-stimulated and being in his room helped him de-escalate. She stated staff placed him in his room for that purpose but R84 was able to self-propel himself back to the common areas. Administrative Nurse D said she believed this is what occurred in July, when the resident struck two other residents. She stated staff had placed him in his room, but he brought himself back out, or staff may have brought him out to the dining room since he required assistance with eating. Administrative Nurse D stated she was unable to speculate if any of the resident to resident abuse events could have been prevented although she stated it appeared the interventions and actions taken to prevent abuse in the two instances (October and July) were not entirely effective . The facility policy Abuse: Prevention of and Prohibition Against revised 01/2021 recorded it was the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility would provide oversight and monitoring to ensure that it's staff, who were agents of the facility, delivered care and services in a way that promoted and respected the rights of the residents to be free from abuse and neglect. The policy documented the facility would train staff to understand behavioral symptoms of the residents which increased the risk of abuse which included aggressive reactions of the residents, wandering type behaviors, resistance to care, and outbursts or yelling out. The policy further recorded the facility would take action to protect and prevent abuse and neglect from occurring within the facility. The facility failed to protect residents from abuse and neglect while investigating episodes and/or allegations of abuse and neglect. The facility further failed to fully investigate, identify, and implement interventions in response to instances of resident to resident abuse. Resident (R) 84, who had a history of aggressive behaviors and striking another resident on 10/20/21 entered R56's room on 10/21/20 and struck him in the face multiple times. On another occasion, at a later date, R84 acted aggressively. Staff failed to implement an immediate intervention, subsequently R84 punched R47. Again, staff failed to implement measures aimed to protect residents and approximately two hours later, R84 hit R71. This deficient practice placed the residents in immediate jeopardy. The facility removed the immediacy at 10:40 AM on 08/03/21 by completing the following actions: Move R84 to Serenity Unit. 1:1 with this resident during waking hours with 15 Minute checks during sleeping hours (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Inpatient referral to be completed on August 4th to find a more appropriate placement for this type of resident with behaviors. IDT completed full audit of all residents on the second floor on August 3, 2021 to determine what residents have the potential to be aggressive and potentially hurt other residents. All residents determined to have the potential to be aggressive or harm residents will have care plan updated, staff informed via jot sheets and the shift change report. Behavioral monitoring audit to be added to the daily clinical meeting. Immediate intervention from staff if there is a resident to resident altercation. Any interaction will need to be reported to DON/ED immediately. All staff will be re-in serviced on this process immediately to be completed by 4:30 pm on Wednesday, August 4th, 2021. Staff will be educated on notifying administration immediately when a resident begins to get upset so that aggression can be avoided, and interventions put in place. - The Diagnoses tab of R21's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, cognitive communication deficit, and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE] documented R21 had a Brief Interview for Mental Status (BIMS) score of six which indicated severe cognitive impairment. R21 had no behaviors during the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/14/21 documented R21 was unable to correctly answer questions during the BIMS interview. The Care Plan dated 01/27/17 documented R21 had dementia and directed staff to administer medications as ordered and monitor/document/report to the medical doctor (MD) any changes in cognitive function. The Care Plan dated 03/19/20, resolved 05/18/21, documented R21 had the potential for lashing out if others got in his space and directed staff to help R21 to maintain safe distance from other residents in common area and to monitor, record, report increased episodes of agitation. The Care Plan dated 03/18/21 documented R21 had the potential to demonstrate physical behaviors related to anger, dementia, and poor impulse control. The Care Plan documented on 03/17/21, R21 grabbed another resident by the left shoulder and bent her forward. The Care Plan directed staff analyzed key times, places, circumstances, triggers, and what escalated behavior and documented. It further directed staff documented observed behavior and attempted interventions and monitored/documented/reported to the MD of danger to self and others. The Care Plan directed when R21 became agitated, staff guided him away from source of distress and engaged R21 calmly in conversation, if his response was aggressive then staff were to walk away calmly and approach later. (continued on next page)

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Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A focus in R21's comprehensive plan of care, recorded that on 03/28/21, R21 grabbed another resident by the wrist and started bending her finger backwards with an intervention on 03/28/21 that R21 moved to another unit. The Notes tab of R21's EMR revealed a Nursing Note on 03/17/21 at 03:28 PM that documented R21 was in the common area by nurses' desk. R21 grabbed an unidentified resident by her left shoulder and bent her forward. R21 yelled that she was stealing and stated, if that bitch keeps stealing, I'll keep ripping her head off. R21 went to his room and the residents were to stay separated throughout the night. The Notes tab of R15's EMR revealed a Nursing Note on 03/17/21 at 03:31 PM that documented R15 sat in chair by nurses' desk. Another resident grabbed her by the shoulder and bent her forward. Staff separated the residents and R15's skin was assessed. R15 had small amount of redness to back of left shoulder. Residents continued to be separated throughout the shift. The Notes tab of R15's EMR revealed a Nursing Note on 03/17/21 at 03:32 PM that documented R15 was involved in resident-to-resident altercation. R15 was grabbed when she took a snack off another resident's tray and was cussed out by the other resident per staff. R15 denied pain upon interview, skin was examined where she was grabbed. Floor staff educated to keep residents away from each other. The Notes tab of R21's EMR revealed a Interdisciplinary (IDT) Note on 03/18/21 at 09:57 AM that documented IDT met to discuss an incident or resident to resident altercation on the previous date. R21 grabbed an unidentified resident by the left shoulder and bent her forward. Staff separated the residents. R21 was upset the resident was taking snacks off his cart. R21 went to his room. Staff was educated to keep residents separated and if one resident went into the common area, the staff were to redirect the other resident to a separate area. Staff were to monitor the residents at that time. The Notes tab of R21's EMR revealed a Nursing Note on 03/19/21 at 05:31 AM that documented R21 was kept away from the female resident, no grabbing was noted. The writer overheard a female resident ask R21 Who are you? R21 replied to the female resident he was a woman killer. The writer intervened and directed R21 not to use that kind of wording to the other resident and directed him to go to his room. The Notes tab of R21's EMR revealed a Nursing Note on 03/20/21 at 05:46 AM that documented R21 was alert and oriented, able to voice needs. Staff continued to monitor R21's behavior towards other residents, no behaviors all shift. The Notes tab of R21's EMR revealed a Nursing Note on 03/20/21 at 02:34 PM that documented R21 had no aggressive or physical outbursts with staff or other residents. The Notes tab of R21's EMR revealed a Nursing Note on 03/26/21 at 02:39 AM that documented R21 had one episode of aggressive behavior in common area where he was verbally threatening female residents. The writer separated R21 and educated him on his inappropriate behavior. R21 was told he would have to go to his room if he continued to be aggressive, R21 calmed down then later went back to his room. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Notes tab of R21's EMR revealed a Nursing Note on 03/29/21 at 03:05 AM that R21 did not have any abnormal aggressive behavior noted at that time and was in his bedroom, staff continued to redirect resident away from other resident. The Notes tab of R21's EMR revealed a Nursing Note on 03/30/21 at 05:05 AM that R21 did not have any aggressive behavior towards any resident that shift. The Notes tab of R21's EMR revealed a Social Services Note on 03/30/21 at 10:16 AM that documented facility left a message for R21's guardian that he moved from second floor to first floor due to increased behaviors. The clinical record lacked further documentation of this resident to resident occurrence on 03/28/21. A review of the Facility Report dated 03/20/21 revealed the following account of the 03/17/21 incident: A resident-to-resident altercation on 03/17/21 that involved R21 with a BIMS of five and R15 with a BIMS of three. The report documented R21 was in the common area eating his lunch when R21 came and grabbed his fudge round cookie off his tray. When R15 took the cookie, this made R21 mad, so he grabbed R21 by the shoulder and held her. Staff heard the commotion and removed R21 from the scene. R21 was angry R15 stole the cookie off his tray. Staff redirected R21 to his room. Initial assessment revealed R15 had some light pink fingernail marks from where R21 grabbed her. An order was put in to monitor R21 for behavioral changes. Staff were notified of the situation and advised to redirect R21 back to his room, so the two residents were not near each other. Corrective actions taken in response to the incident included R21 was moved to first floor to keep him separate from residents who wander. Upon request, the facility was unable to provide a Facility Report for the resident-to-resident altercation on 03/28/21. The Orders tab of R15's EMR documented an order with a start date of 03/28/21 to monitor wrist and finger for bruising for any signs/symptoms of injury and to notify primary care provider as soon as possible for any bruising or any change of condition. The clinical record for R15 lacked documentation for the resident-to-resident altercation on 03/28/21. On 08/04/21 at 07:30 AM, R21 laid in bed with his eyes closed. He appeared comfortable and without signs or symptoms of distress or discomfort. No behaviors noted. On 08/05/21 at 01:15 PM, R15 sat in a chair in the day room beside another resident. The other resident rested comfortably with her eyes closed in a reclining wheelchair, a weighted blanket laid on top of her lower body. R15 attempted to pull the weighted blanket off the other resident and onto herself. Certified Medication Aide (CMA) R told R15 no and called he [TRUNCATED]

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 100 residents. The sample included 27 residents. One resident (R)49 was reviewed for transfer and discharge. Based on record review and interview, the facility failed to provide written notice of discharge when R49 was discharged to an acute care facility. Findings included: -The resident's electronic medical record (EMR) listed diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion), multiple sclerosis (MS- a progressive disease of the nerve fibers of the brain and spinal cord), hypertension (elevated blood pressure, coronary artery disease (CAD- an abnormal condition that may affect the flow of oxygen to the heart). The Admission Minimum Data Set (MDS) dated [DATE] revealed R49 had Brief Interview for Mental Status (BIM) score of 12, indicating moderately impaired cognition. She required supervision assistance with her Activities of Daily Living (ADLs) and utilized the use of a walker and/or wheelchair. The Quarterly MDS dated [DATE] revealed R49 had a BIMS score of eight indicating moderately impaired cognition. She required extensive assistance of one staff with her ADLs. She used a wheelchair for mobility. The ADL Care Area Assessment (CAA) dated 01/25/21 documented she was a stand-by assist with ADLs and was at risk for ADL decline. The Care Plan dated 01/11/21 instructed staff to observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease in range of motion, withdrawal or resistance to care due to chronic pain related to MS. The Progress Notes tab in the EMR documented that R49 was hospitalized on [DATE] and 06/24/21 after she fell in her room. The EMR Progress Notes or MISC tab lacked documentation that the residents or her representative we sent written notification of discharge for either instance on 06/18/21 or 06/24/21. On 08/05/21 at 08:17AM, R49 was sitting upright in her bed, bedside table across bed with breakfast tray in front of her, pleasant when conversing, no signs of distress noted. In an interview with Administrative Nurse D on 08/05/21 stated that written notification was not sent out to the family or representative when a resident was discharged . In an interview with Social Services X on 08/05/21 at 02:13PM, she stated nursing contacts the family, she also stated she does not send written notification of discharge to the family/representative but does send a monthly discharge report to the ombudsman. She stated she does a bed hold and notifies the family on the phone when a resident is discharged . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide a policy for facility initiated emergency discharge. The facility failed to provide the resident and his/her representative with written notice of discharge as soon as practical when R49 was sent to an emergency acute facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 100 residents. The sample included 27 residents, with eight residents reviewed for bathing. Based on observation, record review, and interviews, the facility failed to provide consistent bathing for eight dependent Residents (R), R8, R11, R65, R79, R50, R69, R88, and R76. This deficient practice created had the potential for poor hygiene and low self-esteem for the affected residents. Findings included: - R8's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R8 was totally dependent of two staff members for activities of daily living (ADL's). The MDS also documented R8 had not received a bath during the look back period. R8's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 05/07/21 documented he required assistance with his personal hygiene. R8's Care Pan dated 01/13/21 documented he preferred a bed bath two times a week instead of a shower. The EMR, under the Tasks tab, documented R8's bath days were scheduled on Tuesdays and Friday's, day shift. The bathing task, reviewed May 1, 2021 through August 3, 2021, revealed R8 had not received a bath. On 08/05/21 at 08:57 AM R8 stated that he preferred a bed bath to a shower. R8 was positioned on his right side in bed on a pressure reducing mattress. R8 had facial hair noted and stated that he does get shaved occasionally, but stated he was not growing a beard. On 08/05/21 at 11:05 AM in an interview, Certified Nurses Aide (CNA) O stated staff check the shower book at the start of the shift to obtain the list of showers/baths for that shift. CNA O stated when a resident refused a bath after two attempts by the staff member, the resident was asked to sign the shower sheet. CNA O stated that not applicable (NA) was documented in the EMR under the bathing tasks when staff had been too busy and had not completed the shower/bath. On 08/05/21 at 12:25 PM in an interview, Administrative Nurse E stated CNA staff would offer a shower/bath and if the resident refused three times, the CNA's would report that to the nurse. Administrative Nurse E stated the nurse would interview the resident and documented in the progress notes why the resident refused the shower/bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated the residents have a bath schedule and it was modified to meet the resident's preference. Administrative Nurse D stated if a resident refused, the nurse documented the reason for the refusal. The facility Bath, Shower policy dated May 2007 documented it is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. The facility failed to provide R8's showers according to his schedule. This placed R8 at risk for poor hygiene and decreased self-esteem. - R11's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), psychosis (any major mental disorder characterized by a gross impairment testing), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 required extensive assistance of two staff members for activities of daily living (ADL). The MDS documented R11 required physical assistance of one staff member for bathing during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R11 was totally dependent of one staff member for ADL's and bathing during the look back period. R11's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/17/20 documented she required extensive assistance of one staff member for ADL's. R11's Care Pan dated 01/14/21 documented she required physical assistance of one staff member direct staff with bathing. Review of the EMR under Tasks tab documented R11 scheduled bath days on Mondays and Thursdays' dayshift. Bathing reviewed from May 1, 2021 August 1, 2021. In May 2021, R11 had received two baths on 05/13/21 and 05/20/21. In June 2021, R11 received three showers on 06/17/21; 06/21/21 and 06/27/21. In July 2021, R11 received a shower on 07/12/2. In August 2021, had not received a bath on 08/02/21. On 08/04/21 at 07:38 AM R11 sat in her wheelchair next to her bed as she watched TV. No behaviors or distress noted. On 08/05/21 at 11:05 AM in an interview, Certified Nurse's Aide (CNA) O stated staff check the shower book at the start of the shift to obtain the list of showers/baths for that shift. CNA O stated when a resident refused a bath after two attempts by the staff member, the resident was asked to sign the shower sheet. CNA O stated that not applicable (NA) was documented in the EMR under the bathing tasks when staff had been too busy and had not completed the shower/bath. On 08/05/21 at 12:25 PM in an interview, Administrative Nurse E stated CNA staff would offer a shower/bath and if the resident refused three times, the CNA's would report that to the nurse. Administrative Nurse E stated the nurse would interview the resident and documented in the progress notes why the resident refused the shower/bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated the residents have a bath schedule and it was modified to meet the resident's preference. Administrative Nurse D stated if a resident refused, the nurse documented the reason for the refusal. The facility Bath, Shower policy dated May 2007 documented it is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. The facility failed to provide R11's showers according to her schedule. This placed R11 at risk for poor hygiene and decreased self-esteem. - R65's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS score of 14 which indicated intact cognition. The MDS documented that R65 required limited assistance one staff member for Activities of Daily Living (ADL's). The MDS documented R65 had not received a bath during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R65 required supervision assistance of one staff, member for ADL's. The MDS documented R65 required physical assistance of one staff member for bathing during the look back period. R65's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 12/01/20 documented she self-propelled her wheelchair and she required limited assistance with ADL's. R65's Care Pan dated 11/14/19 directed staff to encourage her to participate to the fullest extent with each interaction. Review of the EMR under Tasks tab documented R8's bath days were scheduled on Mondays and Thursday's, evening shift. The bathing task, reviewed May 1, 2021 through July 1, 2021, revealed R65 had not received a bath for May 2021. In June 2021, R65 received a shower on 06/21/21; 06/24/21 and 06/28/21. In July 2021, R65 received a shower on 07/05/21; 07/08/21; 07/12/21; 07/15/21; 07/19/21; 07/22/21; 07/25/21 and 07/29/21. On 08/05/21 at 09:07 AM R65 sat in her wheelchair next to the bed. She propelled her wheelchair in the room, she was dressed in a tee shirt and incontinent brief, no distress or behaviors noted. On 08/05/21 at 11:05 AM in an interview, Certified Nurses Aide (CNA) O stated staff check the shower book at the start of the shift to obtain the list of showers/baths for that shift. CNA O stated when a resident refused a bath after two attempts by the staff member, the resident was asked to sign the shower sheet. CNA O stated that not applicable (NA) was documented in the EMR under the bathing tasks when staff had been too busy and had not completed the shower/bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 12:25 PM in an interview, Administrative Nurse E stated CNA staff would offer a shower/bath and if the resident refused three times, the CNA's would report that to the nurse. Administrative Nurse E stated the nurse would interview the resident and documented in the progress notes why the resident refused the shower/bath. On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated the residents have a bath schedule and it was modified to meet the resident's preference. Administrative Nurse D stated if a resident refused, the nurse documented the reason for the refusal. The facility Bath, Shower policy dated May 2007 documented it is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. The facility failed to provide R65's showers according to her schedule. This placed R65 at risk for poor hygiene and decreased self-esteem. - R79's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R79 required limited assistance of one staff member for activities of daily living (ADL's). The MDS also documented R79 required physical assistance of one staff member for bathing. The Quarterly MDS dated [DATE] documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented R79 required limited assistance of one staff member for ADL's. The MDS also documented R79 required physical assistance of one staff member for bathing. R79's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 12/22/20 documented she required limited assistance with her ADL's. R79's Care Pan dated 08/04/17 documented she required assistance of one staff member for bathing activity. The EMR, under the Tasks tab, documented R79's bath days were scheduled on Mondays and Thursday's, evenings. The bathing task, reviewed May 1, 2021 through August 3, 2021. In May 2021, R79 received a shower two times, on 05/10/21 and 05/27/21. On June 2021, R79 received a shower five times, on 06/03/21; 06/10/21; 06/21/21; 06/24/21 and 06/28/21. In July 2021, R79 received five showers, on 07/08/21; 07/12/21; 07/15/21; 07/22/21 and 07/29/21. In August 2021, R79 had not received a shower. On 08/02/21 at 08:18 AM R79 sat in her wheelchair on a pressure reducing cushion, worked on her find the word book, as she waited for her breakfast. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 11:05 AM in an interview, Certified Nurses Aide (CNA) O stated staff check the shower book at the start of the shift to obtain the list of showers/baths for that shift. CNA O stated when a resident refused a bath after two attempts by the staff member, the resident was asked to sign the shower sheet. CNA O stated that not applicable (NA) was documented in the EMR under the bathing tasks when staff had been too busy and had not completed the shower/bath. On 08/05/21 at 12:25 PM in an interview, Administrative Nurse E stated CNA staff would offer a shower/bath and if the resident refused three times, the CNA's would report that to the nurse. Administrative Nurse E stated the nurse would interview the resident and documented in the progress notes why the resident refused the shower/bath. On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated the residents have a bath schedule and it was modified to meet the resident's preference. Administrative Nurse D stated if a resident refused, the nurse documented the reason for the refusal. The facility Bath, Shower policy dated May 2007 documented it is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. The facility failed to provide R79's showers according to her schedule. This placed R79 at risk for poor hygiene and decreased self-esteem. 41713 -The electronic medical record (EMR) documented the following diagnoses for R50: Bell's palsy (temporary weakness or paralysis on one side of the face), type 2 diabetes mellitus (- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling), asthma (disorder of narrowed airways that caused wheezing and shortness of breath), and muscle weakness (decreased strength in muscles). The Admission Minimum Data Set (MDS) dated [DATE] revealed R50 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. She required supervision to limited assist of on staff with her activities of daily living (ADLs). She required partial/moderate assistance with bathing. She walked with use of a cane. The Quarterly MDS dated [DATE] revealed she had a BIMS score of 15, which indicated intact cognition. She was independent with most ADLs, needed limited assist of one staff with personal hygiene. She required physical assistance of one staff with part of bathing activity. The ADL Care Area Assessment (CAA) dated 03/18/21 revealed she required assistance from staff with ADLs. She ambulated with a cane. She was at risk for ADL decline related to recent falls prior to admission. The Care Plan dated 03/17/21 for ADLs directed staff of one to limited assist with toilet use, transfers, bed mobility, and dressing. There was not a specific intervention for bathing. In EMR under the Tasks for ADLs tab for bathing report for the month of April 2021 revealed that R50 only received at shower/bath five of 30 days. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Tasks tab for ADLs report for bathing May 2021 revealed that R50 received a shower/bath on four of 31 days. The Tasks tab for ADLs report for bathing in June 2021 revealed R50 received a shower/bath on five of 30 days. The Tasks tab for ADLs report for bathing in July 2021 revealed R50 received a shower/bath on two of 31 days. The Progress Notes tab lacked any documentation stating reasons why shower/bath was missed or not given on scheduled days. On 08/02/21 at 10:11AM, R50 stated that she would like a full shower more often. She often only gets a partial shower where they wash her hair and just wipe off the rest of her skin with this bath cloth. She also stated that staff does not have the time to give her a full shower. R50 had a calendar in her room that had the days that she had a full shower marked on it. On 08/04/21 at 12:45PM, R50 was resting in her recliner in her room, no signs of distress. In an interview with Certified Nurse Aide (CNA) O on 08/05/21 at 11:34 AM stated there is a care book at the nurse's station that has a laminated list in it of when the residents get a bath/shower and on which days. The nurse makes out a list each morning that is given to the CNAs when they begin their shift that lists which residents gets bath/showers that day. The CNA charts under Tasks when a bath is given and how much help they provided. If a resident refuse, there is a paper the resident signs saying they refused. If NA is charted that means the CNA did not have time to give the shower/bath. In an interview with Licensed Nurse (LN) FF 08/05/21 at 1:11PM stated each hall has a bath assignment sheet that she filled out each morning assigning the CNAs who was to get a bath that day. She stated staff would ask the resident at least twice if they wanted a bath that day. If a resident refused a bath sheet is filled out and a comment is put on the sheet as to why they refused, then she would make an entry in a progress note documenting why resident refused. If NA was charted she would think a shower/bath wasn't done, but there should be something charted as to why it wasn't given. In an interview with Administrative Nurse E on 08/05/21 at 12:11PM stated they look to see if a resident has refused a bath and how long it has been since a resident had a bath. Residents can refuse. Staff does offer alternative to a regular bath like a bed bath wear they wash their arms and legs. For some time, schedules for baths were not lining up and they were not getting done. In an interview with Administrative Nurse D on 08/05/21 at 3:48PM stated residents had a base bathing schedule staff used. Residents are asked their preferences for bathing when admitted . The CNAs are given a bath assignment sheet each morning that lists the residents that are to be bathed that day. If a resident refused staff need to ask why and try again later in the day. The nurse should document in a progress note that resident refused and a reason why. The facility policy Routine Procedures: Bath, Shower revised 05/2007 documented: It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. (continued on next page)

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	175298	A. Building B. Wing	08/05/2021

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure that R50, who required assistance with bathing, received the necessary services to maintain personal hygiene, which had the potential for impaired hygiene and decreased psychosocial well-being. 42966 - R69 admitted to facility on 07/01/21. The Diagnoses tab of R69's Electronic Medical Record (EMR) documented diagnoses of neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems) The Admission Minimum Data Set (MDS) dated [DATE], documented R69 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R69 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Bathing did not occur during assessment period. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/08/21, documented R69 required extensive/total assistance with ADLs and was at risk for complications. The Care Plan dated 07/02/21, documented R69 had ADL self-care performance deficit related to extensive/total assistance with ADLs and was at risk for complications and directed R69 required extensive assistance with personal hygiene. The Care Plan dated 07/14/21, documented R69 had paraplegia and directed staff assisted R69 with ADLs and locomotion as required and encouraged her to perform as much as possible of those activities. The Tasks tab of R69's EMR documented a scheduled task for bathing on Monday and Thursday evenings. The Documentation Survey Report for July and August 2021 revealed R69 received a sponge bath three times in July on 07/19/21, 07/21/21, and 07/29/21; not applicable (NA) was documented on 07/01/21, 07/05/21, 07/08/21, 07/12/21, and 07/26/21; and missing scheduled bathing documentation on 07/15/21 and 08/02/21. On 08/04/21 at 07:34 AM, R69 laid in bed with her eyes closed. She leaned to the left side in bed and appeared comfortable. No signs of distress or discomfort noted. On 08/02/21 at 03:00 PM, R69 stated bathing had not been completed as scheduled and she had not received her first shower/bath until two weeks after admission. She stated she had received three showers/baths since admission. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 01:29 PM, Certified Nurse Aide (CNA) N stated baths were completed by whichever aide was assigned and bathing was charted in Point of Care (POC- EMR system for CNA charting). If a resident refused bathing, she attempted two to three times then had another staff member try to convince the resident to bathe. Refusals for bathing were documented in POC. NA meant not applicable and she charted NA if the facility was short staffed and they were not able to get the scheduled residents bathed. On 08/05/21 at 03:38 PM, Licensed Nurse (LN) FF stated baths were completed by the CNAs and charted in POC. If a resident refused, then it was also documented on the shower sheet and why the resident refused. The shower sheet was given to the nurse to sign. On 08/05/21 at 03:48 PM, Administrative Nurse D stated resident had a modified bathing schedule to meet the resident's preference. If a resident refused, the nurse documented the reason for the refusal. The facility's Bath, Shower policy, last revised May 2007, directed the facility promoted cleanliness, stimulated circulation, and assisted in relaxation. The policy directed all appropriate information was documented in the medical record. The facility failed to provide bathing for dependent R69. This placed the resident at risk for poor hygiene and decreased self-esteem. - The Diagnoses tab of R88's Electronic Medical Record (EMR) documented diagnoses of muscle weakness, unsteadiness on feet, and need for assistance with personal care. The Admission Minimum Data Set (MDS) dated [DATE] documented R88 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R88 was independent with bed mobility, transfers, walking, dressing, toileting, and personal hygiene but required set up help with bathing. The Quarterly MDS dated [DATE] documented a BIMS score of 15. R88 was independent with bed mobility, transfers, walking, dressing, toileting, and personal hygiene; bathing did not occur during assessment period. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 01/11/21, documented R88 was at risk for ADL decline related to decreased functional mobility and weakness. The Care Plan dated 01/04/21, documented R88 had ADL self-care performance deficit related to decreased functional mobility and weakness. R88 required set up with bathing and could bathe independently. The Tasks tab of R88's EMR documented a task for bathing on Wednesday and Saturday mornings. The Documentation Survey Report for July and August 2021 revealed R88 did not receive a shower in July or August; missing scheduled bathing documentation on 07/03/21 and 07/14/21; and not applicable (NA) charted for 07/21/21, 07/24/21, 07/31/21, and 08/04/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/04/21 at 10:37 AM, R88 sat in a chair in the day room, eyes open. He appeared comfortable and without signs of distress. On 08/05/21 at 01:29 PM, Certified Nurse Aide (CNA) N stated baths were completed by whichever aide was assigned and bathing was charted in Point of Care (POC- EMR system for CNA charting). If a resident refused bathing, she attempted two to three times then had another staff member try to convince the resident to bathe. Refusals for bathing were documented in POC. NA meant not applicable and she charted NA if the facility was short staffed and they were not able to get the scheduled residents bathed. On 08/05/21 at 03:38 PM, Licensed Nurse (LN) FF stated baths were completed by the CNAs and charted in POC. If a resident refused, then it was also documented on the shower sheet and why the resident refused. The shower sheet was given to the nurse to sign. On 08/05/21 at 03:48 PM, Administrative Nurse D stated resident had a modified bathing schedule to meet the resident's preference. If a resident refused, the nurse documented the reason for the refusal. The facility's Bath, Shower policy, last revised May 2007, directed the facility promoted cleanliness, stimulated circulation, and assisted in relaxation. The policy directed all appropriate information was documented in the medical record. The facility failed to provide bathing for dependent R88. This placed the resident at risk for poor hygiene and decreased self-esteem. - R76 admitted to facility 04/23/21, discharged to hospital 05/28/21, readmitted to facility 06/02/21, discharged to hospital 06/03/21, and readmitted to facility 06/05/21. The Diagnoses tab of R76's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness and unsteadiness on feet. The Annual Minimum Data Set (MDS) dated [DATE] documented R76 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. She required total dependence with two staff members for bed mobility, transfers, dressing, and toileting; extensive physical assistance with two staff members for personal hygiene and bathing. The Quarterly MDS dated [DATE], documented R76 had a BIMS score of 15. She required total dependence with two staff members for bed mobility, transfers, dressing, bathing, and toileting. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 04/30/21, documented R76 required total dependence with ADLs. The Care Plan dated 04/24/21, documented R76 was totally dependent on staff to provide bathing as necessary. The Tasks tab of R76's EMR documented a task for bathing on Wednesday and Saturday evenings. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Documentation Survey report for April through August 2021 revealed R76 received a sponge bath on 04/27/21, 04/30/21, 05/15/21, 06/30/21, 08/04/21; a full body bath on 05/24/21; a shower on 07/07/21, 07/14/21; missing scheduled bathing documentation on 04/24/21 and 06/23/21; not applicable (NA) charted for 04/28/21, 05/01/21, 05/05/21, 05/08/21, 05/12/21, 05/19/21, 05/22/21, 05/26/21, 06/09/21, 06/12/21, 06/16/21, 06/19/21, 06/04/21, 07/28/21. On 08/04/21 at 08:54 AM, R76 laid in bed with head of bed elevated between 45 to 60 degrees and ate breakfast independently. She appeared comfortable and without signs of distress. On 08/02/21 at 02:48 PM, R76 was upset and stated she had not received bathing regularly and had received two showers since admission in April 2021. On 08/05/21 at 01:29 PM, Certified Nurse Aide (CNA) N stated baths were completed by whichever aide was assigned and bathing was charted in Point of Care (POC- EMR system for CNA charting). If a resident refused bathing, she attempted two to three times then had another staff member try to convince the resident to bathe. Refusals for bathing were documented in POC. NA meant not applicable and she charted NA if the facility was short staffed and they were not able to get the scheduled residents bathed. On 08/05/21 at 03:38 PM, Licensed Nurse (LN) FF stated baths were completed by the CNAs and charted in POC. If a resident refused, then it was also documented on the shower sheet and why the resident refused. The shower sheet was given to the nurse to sign. On 08/05/21 at 03:48 PM, Administrative Nurse D stated resident had a modified bathing schedule to meet the resident's preference. If a resident refused, the nurse documented the reason for the refusal. The facility's Bath, Shower policy, last revised May 2007, directed the facility promoted cleanliness, stimulated circulation, and assisted in relaxation. The policy directed all appropriate information was documented in the medical record. The facility failed to provide bathing for dependent R76. This placed the resident at risk for poor hygiene and decreased self-esteem.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 100 residents. The sample included 27 residents with one resident reviewed for hospice. Based on observations, record reviews, and interviews, the facility failed to ensure hospice services were documented and communicated to staff for Resident (R) 34. This deficient practice had the potential for miscommunication between staff and the hospice provider and a potential for missed hospice service opportunities for R34. Findings included: - R34 originally admitted to facility 02/14/19. R34 sent to hospital for evaluation and treatment following a fall on 07/22/21 and readmitted to facility on 07/23/21. The Diagnoses tab of R34's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure); dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance; history of falling; malignant neoplasm (cancerous tumor [abnormal growth] that can grow uncontrolled and spread to other parts of the body) of head, face, and neck; and squamous (flat cells that make up the outermost layer of the skin) cell carcinoma of skin (skin cancer that begins in squamous cells and is characterized by abnormal, accelerated growth of squamous cells). The Annual Minimum Data Set (MDS) dated [DATE], documented R34 had a Brief Interview for Mental Status (BIMS) score of five which indicated severe cognitive impairment. R34 required total dependence with two staff members for bed mobility, transfers, dressing, toileting, bathing, and personal hygiene; extensive physical assistance with one staff member for locomotion off the unit; limited physical assistance with one staff member for locomotion on the unit; and supervision with setup help only with eating. She was not on hospice at the time of assessment. The Quarterly MDS dated [DATE], documented R34 had a BIMS score of eight which indicated moderate cognitive impairment. R34 required total dependence with two staff members with bed mobility, transfers, dressing, toileting, and personal hygiene; limited assistance with one staff member with locomotion off the unit; and independent with setup help only with eating. She was not on hospice at the time of assessment. A Significant Change MDS was in progress. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/05/21, documented R34 was alert and oriented but was easily agitated and she was very argumentative. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA dated 03/05/21, documented R34 was dependent on staff for her ADLs. The Care Plan dated 01/08/21, documented R34 had actual impairment to skin integrity related to squamous cell carcinoma lesion to the right side of the forehead and directed staff encouraged compliance with dressing changes to cancer lesion on the right side of the forehead. The Care Plan did not address hospice. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice Communication Book for R34 lacked a plan of care for hospice services. The book also lacked direction on what supplies and services hospice provided to R34. The Notes tab of R34's EMR revealed a Nursing Note on 07/24/21 at 11:02 AM that documented R34 had just had a hospice assessment. The Notes tab of R34's EMR revealed a Nursing Note on 07/26/21 at 05:05 PM that documented R34 continued on hospice and had a visit from hospice. The Notes tab of R24's EMR revealed a Nursing Note on 07/27/21 at 06:45 PM that documented R34 continued on hospice. The clinical record lacked documentation, except the above Nursing Notes, of R34's admission to hospice after her return to the facility from the hospital on 07/23/21. On 08/04/21 at 07:33 AM, R34 laid in bed on her right side, bed in lowest position with extra mattress on floor beside her. R34 appeared comfortable and without signs of discomfort or distress. On 08/05/21 at 02:32 PM, Certified Nurse Aide (CNA) Q stated R34 was on hospice and when hospice brought supplies in, they were brought in a bag. She stated information on hospice services for R34 would have been in her hospice binder. On 08/05/21 at 02:34 PM, Certified Medication Aide (CMA) S stated the care plan usually documented a resident was on hospice and she knew what medications were provided by hospice from report when a resident went on hospice. On 08/05/21 at 04:10 PM, Administrative Nurse D stated hospice services should have been on the care plan and in the orders. She stated hospice brought a binder with hospice supplies in for residents on hospice. The facility's End of Life Care; Hospice policy, last revised December 2019, directed the facility provided end of life care for dying residents that emphasizes prevention and relief of symptoms as well as compassionate attention to the resident's dignity and preferences. The policy directed when a change in diagnosis or prognosis indicates a terminal condition, a palliative care assessment was conducted by the Interdisciplinary Team. The policy directed a care plan was developed based on the individualized assessments, the desires of the resident/surrogate decision-maker, and the physician's orders. The policy directed collaboration with hospice included processes for orienting staff to facility policies and procedures which may have included: resident rights, documentation and record keeping requirements. The facility failed to ensure hospice services were documented and communicated to staff for R34. This deficient practice had the potential for miscommunication between staff and the hospice provider and a potential for missed hospice services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40688 The facility identified a census of 100. The sample included 27 residents with three residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on record review, observations, and interviews the facility failed to provide timely interventions for the treatment of a stage two (partial thickness wound presenting as a shallow open ulcer with a red or pink wound bed, without slough) pressure injury acquired in the facility for Resident (R) 67. The facility also failed to implement interventions in place to prevent formation, promote healing and prevent recurrence of pressure ulcers for R67 and R40. Findings included: - R67's diagnoses, listed under the Diagnosis tab in his electronic medical record (EMR) included severe protein-calorie malnutrition, dementia (progressive mental disorder characterized by failing memory, confusion), and heart failure. The Admission Minimum Data Set (MDS) dated [DATE] documented R67 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. He required extensive assistance of two staff members for bed mobility and transfers. The MDs recorded R67 was at risk for pressure injuries but had no unhealed pressure injuries at the time of the assessment, he had a pressure reducing device to his bed and was on a turn and reposition program. The Pressure Ulcer Care Area assessment dated [DATE] documented R67 was hospitalized after an accident in his motorized wheelchair and he suffered multiple fractures including his right femur (thigh bone). He was dependent on staff for activities of daily living (ADLs), was always incontinent and was at risk for skin injury. He had a surgical incision from his recent gastrostomy tube (tube for introducing high calorie fluids into the stomach) placement. Proceed to care plan for daily skin assessments during check and change and skin assessments done by licensed nurse. The Quarterly MDS dated [DATE] documented R67 had a BIMS of nine which indicated moderate cognitive impairment. He was totally dependent on two staff members for bed mobility and transfers. He did not walk. He was at risk for pressure injuries and had one unhealed stage two pressure ulcer that was not present on admission. He had a pressure reducing device to his bed and chair but did not have a turn and reposition program. He received pressure ulcer treatments. The Care Plan created on 02/06/21 and revised on 05/02/21 documented a focus which recorded R67 had an actual impairment to his skin integrity regarding a stage two pressure ulcer to his right heel, decreased functional mobility, weakness, incontinence of bowel and bladder and was dependent on staff for transfers and bed mobility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan listed the following interventions dated 02/06/21; staff kept R67's fingernails short to avoid scratching and to kept hands and body parts from excessive moisture. It directed staff to educate caregivers, family and R67 on causative factors and measures to prevent skin injury and to encourage good nutrition and hydration. The plan of care further directed R67 required a pressure reducing mattress, wheelchair cushion, and caution during transfers. An interventions dated 03/09/21 recorded R67 was provided a heel lift. The Care Plan further documented the following active intervention dated 04/16/21 one time daily every Monday, Wednesday and Friday and as needed for heel pressure wound: Cleanse and pat dry. Apply skin prep (liquid skin barrier) to surrounding tissue. Cover with foam adhesive. Check dressing for placement and saturation and change if needed. The Care Plan recorded another active intervention, dated 04/23/21, that directed staff R67 required a heel lift/suspension foam boot to right foot at all times. Review of the assessment tab in R67's EMR revealed the following assessments: The Admission assessment dated [DATE] and locked on 01/19/21 documented R67 had no pressure ulcers. The Initial Admission Record dated 03/01/21 recorded R67 had no skin issues but staff were monitoring bilateral heels, buttocks, and abdomen. The Skin Assessments, dated 03/08/21, 0315/21, 03/23/21, 03/29/21, 04/05/21, 04/12/21, 04/20/21 and 04/27/21 documented R67 skin was intact with no issues. The Pressure Ulcer Weekly assessment dated [DATE] listed the assessment as the initial assessment. It recorded a stage two ulcer to the right heel with an onset date of 01/12/21. The wound measured 0.6 centimeters (cm) by(x) 0.7 cm with 0.6 cm depth. There was no exudate (drainage) and the wound bed was pink. The treatment listed bordered foam every 3 days and as needed (PRN). The Pressure Ulcer Weekly assessment dated [DATE] recorded a stage two ulcer to the right heel. The wound measured 0.6cm x 0.6 cm with 0.1 cm depth. There was scant serous (clear) exudate and the wound bed was pink. The treatment listed bordered foam every 3 days and PRN. The Pressure Ulcer Weekly assessment dated [DATE] recorded a stage two ulcer to the right heel. The wound measured 0.6 cm x 0.7 cm with 0.1 cm depth. There was scant serous exudate and the wound bed was pink. The treatment listed bordered foam every 3 days and PRN. The Pressure Ulcer Weekly assessment dated [DATE] recorded a stage two ulcer to the right heel. The wound measured 0.3 cm x 0.3 cm with 0.1 cm depth. There was no exudate and the wound bed was pink. The treatment listed bordered foam every 3 days and PRN. The Pressure Ulcer Weekly assessment dated [DATE] recorded a stage two ulcer to the right heel. The wound measured 0.6 cm x 0.5 cm with 0.1 cm depth. There was scant serous exudate and the wound bed was pink. The treatment listed bordered foam every 3 days and PRN. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Ulcer Weekly assessment dated [DATE] recorded a stage two ulcer to the right heel. The wound measured 0.8 cm x 0.6 cm with 0.1 cm depth. There was scant serosanguinous (semi-thick reddish drainage) exudate and the wound bed was pink. The treatment listed bordered foam every 3 days and PRN. The Pressure Ulcer Weekly assessment dated [DATE] recorded a stage two ulcer to the right heel. The wound measured 0.7 cm x 0.7 cm with no depth. There was no exudate and the wound bed was pink. The wound was noted with fibrotic callous. The treatment listed callous formation; skin prep applied. The Pressure Ulcer Weekly assessment dated [DATE] recorded a stage two ulcer to the right heel. The wound measured 0.7 cm x 0.7 cm with 0.1 cm depth. There was scant serous exudate and the wound bed was pink. The treatment listed bordered foam every 3 days and PRN. Review of the Progress Notes tab in R67's EMR revealed the following: A Skin/Wound Note Late Entry dated 03/31/21 recorded R67 was consulted for wound care per Consultant HH. The chief complaint listed right heel ulcer. The history of present illness (HPI) documented nursing staff at the facility noted an open wound to the resident's right heel the week of 03/29/21. Offloading was initiated with heel lift and bunny boots (soft boots used to prevent and heal pressure ulcers to the feet). The assessment documented the right heel presented with a 0.4 x 0.6 x 0.1 cm open ulceration. Wound bed was 101 percent (%) pink and smooth tissue. Edges were attached and non-rolling. Surrounding tissue had blanchable erythema (redness). Moderate serosanguineous drainage was present on previous dressing. The plan directed to cleanse and pat dry, apply skin prep to surrounding tissue, cover with adhesive foam and change every three days or as needed if dressing was loose or saturated. Continue heel float at bedtime along with offloading boots. A Skin/Wound Note Late Entry dated 04/14/21 recorded R67 was consulted for wound care per Consultant HH. The chief complaint listed right heel ulcer. The assessment documented the right heel presented with a 0.6 x 0.6 x 0.1 cm open ulceration. Wound bed was 101 percent (%) pink and smooth tissue. Edges were attached and non-rolling. Surrounding tissue had blanchable erythema. Moderate serosanguineous drainage was present on previous dressing, no odor noted. The plan directed to cleanse and pat dry, apply skin prep to surrounding tissue, cover with adhesive foam and change every three days or as needed if dressing was loose or saturated. Continue heel float at bedtime along with offloading boots. A IDT (interdisciplinary) Note documented R67 had a wound stage two to his right heel with treatments in place. A Nursing Note dated 07/04/21 at 5:39 PM documented R67 complained of right heel pain. A Nursing Note dated 07/05/21 at 5:55 AM documented R67 complained of heel pain. Review of R67's physician's orders under the Orders tab revealed the following: An order dated 03/01/21 (discontinued on 07/13/21) for pressure reducing mattress every shift. (continued on next page)

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Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An ordered dated 04/15/21 (discontinued on 07/13/21) directed wound care to the right heel one time every day on Monday, Wednesday, and Friday for heel pressure wound. Cleanse and pat dry. Apply skin prep to surrounding tissue and cover with foam adhesive. An ordered dated 04/15/21 (discontinued on 07/13/21) directed wound care to the right heel as needed. Check dressing for placement and saturation. Change if needed. An order dated 04/22/21 (discontinued on 05/29/21) for heel lift suspension foam boot to right foot at all times every shift for right heel pressure wound. An order dated 05/29/21 (discontinued on 07/13/21) for heel lift suspension foam boot to right foot at all times every shift for right heel pressure wound. Review of the Tasks tab in R67's EMR revealed the following: In March 2021, Floating heels (FH) or Prafo Boots (PB-heel lift boots) were documented as used/performed six of 93 shifts. In April 2021, FB and/or PB were charted as provided three out of 90 shift opportunities. In May 2021, FB and/or PB were charted as provided two out of 93 shift opportunities. In June 2021, FB and/or PB were charted as provided 10 out of 90 shift opportunities. In July 2021, FB and/or PB were charted as provided 13 out of 93 shift opportunities. On 08/02/21 at 09:49 AM R67 laid in bed, on his back, on a low air loss mattress. The bed was in a low position. The air mattress pump sat on the floor at the foot of the bed. Both R67's feet rested directly on the mattress. A blue heel-lift boot laid on the room floor under a wheelchair. On 08/03/21 at 07:27 AM R67 laid in bed on his left side, feet resting directly on the mattress with no heel -lift boots on either foot. On 08/04/21 at 07:28 AM R67 laid in bed, on his back. The air mattress pump sat on the floor at the foot of the bed. R67's heels rested directly on the mattress with no heel-lift boots applied. On 08/04/21 at 10:05 AM R67 rested in bed, on his back. R67 had a foam device under his legs and heels were floated. Blue heel-lift boots were observed in the chair, next to the bed. On 08/04/21 at 04:20 PM R67 rested in bed, on his back. His heels were floated, and he had heel lift boots on both feet. On 08/05/21 at 07:47 AM, staff assisted R67 to bed via a mechanical lift. Staff positioned R67 in bed, placed a foam insert under legs to float his heels. Staff did not apply the heel boots to R67's right foot. A round dried, dark red and brown scab was present, open to air, on R67's right heel. The surrounding skin was flaky and dry. The left heel appeared pink. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/21 at 11:39 AM Certified Nurse Aid (CNA) O stated the CNAs found out how to care for the residents during rounds and verbal report. The CNA would pass on any resident likes, specific resident needs or cares and how the residents transfer. CNA stated the CNA could also get the information from the care plan in the computer. She said the CNAs saw something like a skin problem reported it right away and the nurses told them what they needed to do as far as any cares or special skin related tasks. On 08/05/21 at 12:00 PM CNA P stated for basic skin care, the CNA showered the residents, applied lotion and always applied barrier cream when providing peri-care. She stated if she noted a skin issue on a resident, she reported it to a nurse right away. CNA P said if a resident had a pressure ulcer, CNA staff would turn and reposition the resident every two hours. She went on to say the facility had boots they placed on residents who were at risk for ulcers and the boots kept the feet off the bed and prevented wounds from developing. On 08/05/21 at 12:30 PM Administrative Nurse E stated she was uncertain if R67 had any wounds. She said the facility had a wound nurse that came in weekly to assess wounds. She further stated a facility nurse rounded with the wound nurse, so the facility nurse updated the wound nurse on any issues. She stated the charge nurses did not the direct line to the wound nurse so if new skin issues and pressure injuries were identified, the charge nurse would notify one of the administrative nurses or the nurse who made rounds with the wound nurse. Administrative Nurse E stated the facility had standing orders to deal with most wound issues including pressure injuries. Administrative Nurse E stated the facility nurses did not measure or assess wounds; they just implemented a treatment order after the wound nurse was contacted. She stated the nurse wound did all wound evaluations, measurements and evaluation of the effectiveness of the treatments. 08/05/21 at 03:50 PM Administrative Nurse D stated had standard pressure ulcer prevention measures. She stated if an open area was noted the nurse entered a treatment order based on what the wound required. The facility then notified the wound nurse. Administrative Nursed D stated residents at risk for pressure injuries would have a turning and reposition program and nursing would evaluate nutrition and hydration. She stated to prevent or promote healing of heel ulcers, the facility would implement heel boots and ensure the heels were floated whenever the resident was in bed. She further stated interventions were ideally entered into the EMR as orders on the treatment record and put on the care plan and Kardex (electronic tool giving instruction on resident care). Administrative Nurse D stated the facility charge nurses currently were not doing this, the administrative nurses were responsible for entering the orders and updating the care plan and the task list. She stated if the orders and care plan indicated a resident needed heel lift boots, she expected staff would apply them as needed. The facility policy , dated 10/2020, titled Pressure Ulcer Skin Monitoring and Management recorded it was the policy of the facility that a resident who entered the facility without pressure ulcers would not develop pressure ulcers unless the individual's clinical condition or other factors demonstrated a pressure ulcer was unavoidable. The policy documented nursing staff would continue preventative measures such as pressure reduction. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to prevent the development of a stage two facility acquired pressure ulcer to R67's right heel. The facility failed to respond to the newly developed ulcer in a timely manner when they waited 15 days after the ulcer developed and was assessed to establish a treatment order in R67's medical record. The facility further waited 22 days after the wound was assessed and treatment plan established to enter the orders and direction in the clinical record to apply the hell lift boots to the right heel. The facility failed to follow the plan of care when they failed to ensure R67's had his heel lift boots applied to his right foot at all times per the plan of care. 41037 - R40's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), chronic kidney disease (CKD, damaged kidneys and unable to filter blood the way they should), end stage renal disease (ESRD- inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes) and dependence on renal dialysis, and malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R40 required extensive assistance of two staff members for Activities of Daily Living (ADL's). The MDS documented R40 was at risk for pressure ulcers and she had a pressure reducing device in her chair. The Quarterly MDS dated [DATE] documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R40 required extensive assistance of one staff member for ADL's. The MDS documented R40 was at risk for pressure ulcers and a pressure reducing devices was in her chair. R40's Pressure Ulcer Care Area Assessment (CAA) dated 04/08/21 documented she was at risk for pressure/skin injuries related to her need for extensive assistance with bowel and bladder incontinence. R40's Care Pan dated 01/07/20 documented that she needed an pressure reducing cushion in the wheelchair to protect her skin when in the chair. Review of the EMR under the Assessment tab revealed Braden assessment dated [DATE] recorded a score of 13 which indicated a moderate risk for skin breakdown; 02/09/21 recorded a score of 16 which indicated a low risk for skin breakdown and 05/09/21 recorded a score of 16 which indicated a low risk for skin breakdown. On 08/02/21 at 07:55 AM R40 sat in a wheelchair in the common area as she watched TV. Her wheelchair lacked a pressure reducing cushion. On 08/05/21 at 11:05 AM in an interview, Certified Nurses Aide (CNA) O stated that all residents in a wheelchair should have a cushion in their wheelchair. On 08/05/21 at 01:11 PM in an interview, Licensed Nurse (LN) stated FF stated she was not absolutely sure which residents needed wheelchair cushions. On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated pressure ulcer prevention measures would be turning, hydration, heel cushion and nutrition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Pressure Ulcer Skin monitoring and Management policy dated October 2020 documented the purpose of this policy was for the resident not to develop a pressure ulcers unless clinically unavoidable. The facility failed to implement pressure reducing equipment for R40, who was at risk for pressure injuries. This placed R40 at increased risk for pressure/skin injuries.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40688 The facility identified a census of 100 residents. The sample included 27 residents with eight residents reviewed for accidents and hazards. Based on observation, record review, and interviews the facility failed to ensure an environment free from the risk of injury due to accidents and /or hazards for Resident (R)41, R67, R94, R56 and R69. The facility failed to provide foot pedals on the wheelchair for R41 and failed to ensure two staff members participated in a Hoyer (mechanical lift) transfer. The facility failed to ensure R94's walker was placed within her reach and failed to ensure R56's bed was placed in a low position and call light placed within reach when he was in bed. The facility failed to implement Dycem (nonslip product used to help stabilize or hold objects firmly in place) in R69's wheelchair as directed by her plan of care to prevent her slipping from her wheelchair. These failures placed the five residents at risk for injuries related to falls and other accidents. Findings included: - R41's diagnoses, listed under the Diagnosis tab in her electronic medical record (EMR) included dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure) and Parkinson's disease slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Admission Minimum Data Set' (MDS) dated [DATE] recorded R41 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. She required extensive assistance of one staff member for activities of daily living (ADLs) which included locomotion on the unit in a wheelchair. The Falls Care Area assessment dated [DATE] documented R41 was at risk for falls due to several falls prior to her admission to the facility. The Quarterly MDS dated [DATE] recorded R41 had a BIMS of one, indicating severe cognitive impairment. She required extensive assistance of one staff member for most ADLs including locomotion on the unit in a wheelchair. She was dependent on staff for bed mobility and dressing. The MDS recorded no falls since the previous assessment (conducted on 06/15/21). The Care Plan initiated on 04/30/21 and revised on 06/25/21 documented R41 was at risk for falls due to her diagnoses of Parkinson's and dementia. An intervention dated 07/20/21 documented R41 had a non-injury fall on 07/19/21. The intervention directed staff to ensure foot pedals were on R41's wheelchair while the resident was up, for positioning. A Fall Committee interdisciplinary Team (IDT) Note in the Progress Notes tab of the EMR recorded the IDT fall care team met to discuss a fall on 07/19/2021. The note recorded staff were to ensure foot pedals were on R41's wheelchair while she was up. On 08/02/21 at 02:00 PM R41 sat in her wheelchair at the nurse station. There were no foot pedals on the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/02/21 at 02:24 PM an unidentified therapy staff pushed R41 in her wheelchair. There were no foot pedals on the wheelchair at that time. On 08/04/21 at 07:32 AM R41 sat in her wheelchair at the nurse station. She wore pink crocs and had no foot pedals on the wheelchair. On 08/04/21 at 09:19 AM R41 transferred to her wheelchair with the assistance of therapy staff. Staff then wheeled her down the hallway to her room. There were no foot pedals present on her wheelchair. On 08/04/21 at 10:06 AM R41 sat in her wheelchair by the nurse station. There were no foot pedals on her wheelchair. Observation of 441's room at that time revealed foot pedals on laying atop stand in R41's room. On 08/04/21 at 04:26 PM R41 laid on the floor of the hallway on her left side. Her wheelchair was parked close by her feet and lacked foot pedals. Certified Nurse Aid (CNA) DD stated she had pushed R41 out of the room and R41 began to lean too far over and CNA DD was unable to stop her from falling from the chair. Administrative Nurse E responded to the fall and told CNA DD she needed to get R41's foot pedals. On 08/05/21 at 11:39AM CNA O stated the CNAs learned from the nurses which residents were at risk for falls /or had new intervention. She stated this information was also on the resident's care plan. She further stated therapy staff would communicate if the resident needed foot pedals or any other adaptive equipment. On 08/05/21 at 11:43 AM CNA P stated if she saw a resident's feet dragging on the ground while being pushed in the wheelchair, she would go get foot pedals for the chair. She stated the CNAs would know what was implemented to prevent falls by verbal report and by checking the resident's Kardex (tool which summarizes the needs of the resident, based on the care plan). On 08/05/21 at 12:30 PM Administrative Nurse E stated the CNAs and nurses passed, in shift report, information about the residents fall risk and any interventions or directions related to the residents' care. She stated R41 was supposed to have foot pedals and then said the information was on the care plan but did not get shared during verbal report. The facility's Fall Reduction Program- Falling Star policy, last revised July 2021, directed the facility promoted personal freedom while providing for reasonable safety measures and all residents in the facility were assessed for, had measures implemented in response to, and were routinely evaluated for changes in their risk for falls. The policy directed if a fall occurred despite initial interventions, the charge nurse put an intervention on the care plan from the list of fall interventions attached to the policy. The care plan must be updated immediately after the fall. Interventions were based on circumstances leading up to the fall. All falls were reviewed by the clinical team the next business day which included post-fall investigation discussion, interventions placed on care plan if applicable, probably cause discussion, walking rounds that assessed interventions were in place, and CNA education was performed. The facility failed to provide the necessary foot pedals to R41's wheelchair when in use. This placed R41 at risk for injuries related to accidents and/or falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R67's diagnoses, listed under the Diagnosis tab in his electronic medical record (EMR) included severe protein-calorie malnutrition, dementia (progressive mental disorder characterized by failing memory, confusion), and heart failure. The Admission Minimum Data Set (MDS) dated [DATE] documented R67 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. He required extensive assistance of two staff members for bed mobility and transfers. The Pressure Ulcer Care Area assessment dated [DATE] documented R67 was hospitalized after an accident in his motorized wheelchair and he suffered multiple fractures including his right femur (thigh bone). He was dependent on staff for activities of daily living (ADLs). The Quarterly MDS dated [DATE] documented R67 had a BIMS of nine which indicated moderate cognitive impairment. He was totally dependent on two staff members for bed mobility and transfers. He did not walk. The MDS recorded R67 had one non-injury fall since the prior assessment. The Care Plan initiated on 01/12/21 recorded R67 had a self-care performance deficit due to decreased functional mobility, and weakness. The Care Plan further documented an active intervention dated 03/08/21 R67 required total assistance with transfers. The Care Plan lacked reference to use of a mechanical lift for transfers. Review of the Progress Notes tab of R67's EMR revealed a Daily Skilled Note dated 04/26/21 which recorded R67 required a Hoyer lift with assistance of two people. In an observation on 08/05/21 at 07:47 AM, an unidentified agency Certified Nurse Aid (CNA) returned R67 to his room after a shower. R67 requested to be placed back in bed. The agency CNA told R67 she would need to get another CNA as Hoyer transfers required two people. R67 told the agency CNA staff transfer him with one person all the time. The agency CNA stated, I am not here all the time, and left the room to get assistance. She returned to the room followed shortly after by CNA P. CNA P positioned the lift over R67, who was in a shower chair. CNA P attached the leg straps from the front and the agency CNA attached the upper straps from behind R67. CNA P then moved to the control portion of the lift and began to raise R67. The agency CNA pulled the shower chair out from under R67 and then moved to the opposite side of the bed and began arranging the bedding and placed a brief on the bed in preparation. CNA P raised R67 into the air, then closed the legs and moved the lift from the end of the bed to the side of the bed and positioned R67 over the bed. While the resident was suspended from the sling and the lift was in motion, there was no staff member stabilizing the resident or preventing the resident from swinging. CNA P began lowering the resident, agency CNA assisted to guide the resident's placement in the bed over the adult brief spread out on the bed. On 08/05/21 at 08:10 AM the agency CNA stated she should have held onto R67's legs and kept him steady during the transfer. ON 08/05/21 at 11:39AM CNA O stated Hoyer lifts required two people for safety reasons. She stated one CNA hooked up the sling and used the controls and the other CNA present followed behind the lift. She stated the staff member who followed the lift stabilized the resident while the lift was in motion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 12:30 PM Administrative Nurse E stated some staff needed two persons hands-on during the Hoyer lift transfer, but this depended on the resident's size. She stated some staff only needed help with the visual aspect of the Hoyer transfer depending on how staff needed to move the bed and the lift. 08/05/21 at 03:50 PM Administrative Nurse D stated the facility required two staff members for all Hoyer lift transfers. Staff were trained specifically for that task. One staff member should be hands-on and guiding the resident, keeping the resident from swinging and providing reassurance to the resident while the other staff member ran the controls. The facility did not provide a policy on staff procedure for Hoyer transfers. The facility failed to ensure two staff members performed a Hoyer transfer for R67, who was dependent on staff for transfers. This placed R67 at risk for accidents and injuries related to use of the Hoyer lift. - R94's diagnoses, listed under the Diagnosis tab in her electronic medical record (EMR) included dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure) and history of falling. The Annual Minimum Data Set (MDS) dated [DATE] documented R94 had a Brief Interview for Mental Status (BIMS) score of 99 and was severely cognitively impaired. She required limited assistance of one staff member for most activities of daily living (ADLs). She required supervision with set up assistance for walking with her walker. She had two or more non-injury falls since the previous assessment. The Dementia Care Area assessment dated [DATE] recorded R94 was confused and became easily agitated. The Quarterly MDS dated [DATE] documented R94 had a Brief Interview for Mental Status (BIMS) score of 99 and was severely cognitively impaired. She required limited assistance of one staff member for most ADLs. She required supervision with set up assistance for walking with her walker. She had two or more non-injury falls since the previous assessment on 06/15/21. R94's Care Plan initiated on 05/23/19 and revised on 06/21/21 documented R94 is at risk for falls due to decreased functional mobility, unsteadiness on her feet, medication side effects, and poor safety awareness. An intervention dated 09/02/20 documented R94 had a non-injury fall on 09/02/20. The interventions directed staff to keep R94's walker close to her. An intervention dated 06/21/21 recorded R94 had a non-injury fall on 06/19/21. She walked in the hallway without her walker, lost balance and fell to the floor. The intervention directed staff to place bright yellow tape on her walker to encourage and remind the resident to use her walker. Review of the progress Notes tab in R94's EMR revealed the following: A Nursing Note dated 06/20/21 at 07:19 AM documented R94 walked without her walker. She lost her balance and was lowered to the floor by nursing staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nursing Note dated 05/18/21 at 07:55 PM documented R94 walked without her walker, lost balance, fell and hit her head which resulted in a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). On 08/04/21 at 04:18 PM R94 slept in a recliner at the nurses' station. R94's walker was placed out of her reach. Another resident was assisted to a chair to R94's right, in between R94 and her walker. On 08/04/21 at 04:44 PM R94 stood up from the recliner. Her walker remained out of reach. She ambulated down the middle hall on Kensington unit with an unsteady gait. Social Services Y, who was assisting another resident with ambulation, was able to hold onto R94's right arm and assist R94 back towards the nurses' station where her walker remained. On 08/05/21 at 11:39AM CNA O stated the CNAs learned from the nurses which residents were at risk for falls /or had new intervention. She stated this information was also on the resident's care plan. She further stated therapy staff would communicate if the resident needed a walker. On 08/05/21 at 11:43 AM CNA P stated the CNAs would know what was implemented to prevent falls by verbal report and by checking the resident's Kardex (tool which summarizes the needs of the resident, based on the care plan). She stated R94 should always have her walker next to her because if she did not, she would get up and walk anyway, and fall. On 08/05/21 at 12:30 PM Administrative Nurse E stated the CNAs and nurses passed, in shift report, information about the residents fall risk and any interventions or directions related to the residents' care. She stated R94 was supposed to have her walker close by all the time. On 08/05/21 at 03:50 PM Administrative Nurse D stated the administrative nurses were responsible for ensuring fall interventions were acted upon. She stated she was uncertain of the exact number of falls for R94 had but she was certain R94 had quite a few. The facility's Fall Reduction Program- Falling Star policy, last revised July 2021, directed the facility promoted personal freedom while providing for reasonable safety measures and all residents in the facility were assessed for, had measures implemented in response to, and were routinely evaluated for changes in their risk for falls. The policy directed if a fall occurred despite initial interventions, the charge nurse put an intervention on the care plan from the list of fall interventions attached to the policy. The care plan must be updated immediately after the fall. Interventions were based on circumstances leading up to the fall. All falls were reviewed by the clinical team the next business day which included post-fall investigation discussion, interventions placed on care plan if applicable, probably cause discussion, walking rounds that assessed interventions were in place, and CNA education was performed. The facility failed to ensure R94's walker was placed within her reach at all times as directed by R94's plan of care. This placed R94 at increased risk for injuries related to falls. - R56's diagnoses, listed under the Diagnosis tab in his electronic medical record (EMR) included aphasia (condition with disordered or absent language function), cerebral infarction (stroke due to lack of oxygen to the brain) and hemiplegia to the right side (paralysis of one side of the body). (continued on next page)

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	175298	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Annual Minimum Data Set (MDS) dated [DATE] documented R56 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated cognitively intact. He was dependent on two staff members for all activities of daily living (ADLs) except eating, for which he was independent after set-up. He had no falls since the previous assessment. The Falls Care Area assessment dated [DATE] recorded R56 was not steady and only able to stabilize with staff assistance. He was at risk for falls due to impaired balance during transitions, difficulty maintaining sitting balance, medication side effects, cognitive communication deficit, and incontinence. The Care Plan initiated on 07/16/18 and revised on 01/13/21 documented R56 was at risk for falls due to right side hemiplegia as a result of a stroke. An intervention dated 07/16/18 directed staff to be sure the call light was within R56's reach and to encourage R56 to use the call light. Another intervention dated 07/16/18 directed staff to ensure R56's bed was in the lowest position. On 08/02/21 at 07:28 AM R56 laid in bed in his room. The bed was in the highest position. The call light was looped through the left side bedrail and hung hallway to the floor. On 08/02/21 at 11:05 AM R56 laid in his bed and leaned to the left side. The bed was in the high position. The call light was looped through the bedrail and hung down towards the floor. R56 could not reach the call light when asked. On 08/04/21 at 07:53 AM R56 laid in his bed and leaned to the left. His bed was in the high position. The call light cord was under R56's left arm and the button hung from the bed by approximately 1.5 feet. On 08/04/21 at 04:23 PM R56 laid in his bed. His bed was in the high position and the call button was on the floor. On 08/05/21 at 11:43 AM CNA P stated the CNAs would know what was implemented to prevent falls by verbal report and by checking the resident's Kardex (tool which summarizes the needs of the resident, based on the care plan). She stated she was somewhat familiar with R56. She stated the bed was left in the high position due to the fact he required total care from staff and staff were unable to provide that care with the bed in low position. She further stated all residents should always have their call lights within reach. On 08/05/21 at 12:30 PM Administrative Nurse E stated the CNAs and nurses passed, in shift report, information about the residents fall risk and any interventions or directions related to the residents' care. On 08/05/21 at 03:50 PM Administrative Nurse D stated the administrative nurses were responsible for ensuring fall interventions were acted upon. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Reduction Program- Falling Star policy, last revised July 2021, directed the facility promoted personal freedom while providing for reasonable safety measures and all residents in the facility were assessed for, had measures implemented in response to, and were routinely evaluated for changes in their risk for falls. The policy directed if a fall occurred despite initial interventions, the charge nurse put an intervention on the care plan from the list of fall interventions attached to the policy. The care plan must be updated immediately after the fall. Interventions were based on circumstances leading up to the fall. All falls were reviewed by the clinical team the next business day which included post-fall investigation discussion, interventions placed on care plan if applicable, probably cause discussion, walking rounds that assessed interventions were in place, and CNA education was performed. The facility failed to ensure R56's bed was left in the low position and his call light placed within reach, as directed in his plan of care. This placed R56, who was at risk for falls, with increased potential for injury related to accidents and/or falls. 42966 - The Diagnoses tab of R34's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and history of falling. The Annual Minimum Data Set (MDS) dated [DATE], documented R34 had a Brief Interview for Mental Status (BIMS) score of five which indicated severe cognitive impairment. R34 required total dependence with two staff members for bed mobility, transfers, dressing, toileting, bathing, and personal hygiene; extensive physical assistance with one staff member for locomotion off the unit; limited physical assistance with one staff member for locomotion on the unit; and supervision with setup help only with eating. She had one non-injury fall since previous assessment. The Quarterly MDS dated [DATE], documented R34 had a BIMS score of eight which indicated moderate cognitive impairment. R34 required total dependence with two staff members with bed mobility, transfers, dressing, toileting, and personal hygiene; limited assistance with one staff member with locomotion off the unit; and independent with setup help only with eating. She had one non-injury fall since previous assessment. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/05/21, documented R34 was alert and oriented but was easily agitated and she was very argumentative. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA dated 03/05/21, documented R34 was dependent on staff for her ADLs. The Falls CAA dated 03/05/21, documented R34 was at risk for falls related to decreased functional mobility, weakness, loss of her right leg, and dependent on staff with bed mobility, transfers, and toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 07/28/19, documented R34 was at risk for falls related to poor balance, unsteady gait, right below-the-knee amputation (surgically removed limb), and frequently incontinent of bowel and bladder. The care plan documented interventions on 06/13/21, 06/30/21, and 07/22/21 to send R34 to emergency room (ER) to evaluate and treat following falls. The care plan documented an intervention on 06/29/21 to place dycem (nonslip product used to help stabilize or hold objects firmly in place) or Velcro to place under wheelchair to prevent cushion from sliding out of wheelchair. The Notes tab of R34's EMR revealed the following Nursing Notes: On 06/13/21 at 04:02 AM the writer heard R34 calling for help and upon entering her room found her lying on her right side on the floor. R34 was bleeding from lesion to right temporal (forehead) area. R34 complained of pain to her left wrist and shoulder. The writer notified the medical doctor that R34 was to be sent to ER for evaluation. On 06/29/21 at 10:09 PM R34 was calling for help, staff entered room to check on her and found her on floor in front of her garbage can with wheelchair behind her. R34 leaned against the wall with right shoulder to wall, wore nonskid socks, call light within reach but not on. R34 stated she tried to throw her wrapper in the garbage and slipped out of the chair. On 06/30/21 at 03:00 PM the writer was notified by Certified Nurse Aide (CNA) that R34 was on the floor in her room. R34 laid on her left side, wheelchair behind resident, wheelchair cushion on edge of the wheelchair without cushion strap attached. R34 unsure of what happened and had a laceration on the left side of her forehead. R34 sent to ER. On 07/22/21 at 06:35 AM the writer called into R34's room immediately after a fall. Large laceration located on forehead, R34 sent to ER. The Notes tab of R34's EMR revealed the following Fall Committee Interdisciplinary (IDT) Notes: On 06/14/21 at 12:09 PM IDT fall care team discussed fall on 06/13/21. R34 was sent to hospital ER for evaluation and treatment. On 06/30/21 at 04:26 PM IDT fall care team discussed fall on 06/29/21. Intervention for staff to order dycem or Velcro to place under wheelchair cushion to prevent cushion from sliding out of wheelchair. On 07/01/21 at 05:20 PM IDT fall care team discussed fall on 06/30/21. R34 was sent to ER for evaluation and treat due to head wound. On 07/23/21 at 06:58 AM IDT fall care team discussed fall on 07/22/21. R34 sent to ER for evaluation and treatment. On 08/05/21 at 10:15 AM R34 laid in bed with head of the bed elevated 45 degrees. She was pleasant and interactive with surveyor. She appeared comfortable and without signs of distress. Her wheelchair was in her room near the bed, no dycem or Velcro noted under the wheelchair cushion, a slide assist was observed under the cushion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 01:29 PM, CNA N stated when a fall occurred, she made sure the resident was not unconscious and notified the nurse. CNA N stated R34 was a fall risk, would get tired but would not tell staff she wanted to go to bed, and wanted to do some things herself. Some fall interventions were extra mattress on the floor beside bed, visual checks during the day, high-back wheelchair, and a wheelchair cushion with a hump between the legs. On 08/05/21 at 03:38 PM, Licensed Nurse (LN) FF stated when a resident fell , she made sure they were comfortable where they were and assessed them. She obtained vital signs, did a skin assessment for injuries, asked the resident what they were doing before they fell , started neurological checks if applicable, and assisted the resident up to a chair or bed. The nurse tried to determine what caused the fall and placed interventions in the care plan. On 08/05/21 at 04:10 PM, Administrative Nurse D stated when a resident had a fall, staff made sure the resident was safe and the CNA notified the nurse. The nurse completed an assessment with vital signs, began neurological checks if a non-witnessed fall, and provided medical treatment. IDT read through the notes from the fall, interviewed staff and residents to determine what happened. The nurse put an intervention in the nursing note but the interventions on the care plan were placed by the IDT team in the fall meeting. She stated interventions were put into place to prevent further falls, sending a resident to ER for evaluation and treatment did not prevent further falls. R34 had dementia and declined care from the nursing staff, she has had several falls. The Director of Nursing (DON) followed up with the interventions within a couple of hours of implementing new fall interventions. She stated dycem would have come from therapy, she was unsure of what a slide assist was. The facility's Fall Reduction Program- Falling Star policy, last revised July 2021, directed the facility promoted personal freedom while providing for reasonable safety measures and all residents in the facility were assessed for, had measures implemented in response to, and were routinely evaluated for changes in their risk for falls. The policy directed if a fall occurred despite initial interventions, the charge nurse put an intervention on the care plan from the list of fall interventions attached to the policy. The care plan must be updated immediately after the fall. Interventions were based on circumstances leading up to the fall. All falls were reviewed by the clinical team the next business day which included post-fall investigation discussion, interventions placed on care plan if applicable, probably cause discussion, walking rounds that assessed interventions were in place, and CNA education was performed. The facility failed to implement effective fall prevention interventions following four falls for R34. This deficient practice had the risk for further falls, possible injuries from falls, and unwarranted physical complications.

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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 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** 41037 The facility identified a census of 100 residents. The sample included 27 residents, with one resident reviewed for hemodialysis (procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observations, record reviews, and interviews, the facility failed to retain dialysis communication sheets and obtain or document vital signs and/or assessments after dialysis for Resident (R) 40. This placed R40 at risk for cause adverse consequences related to dialysis. Findings included: - R40's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), chronic kidney disease (CKD, damaged kidneys and unable to filter blood the way they should), end stage renal disease (ESRD- inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes) and dependence on renal dialysis, and malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R40 required extensive assistance of two staff members for Activities of Daily Living (ADL's). The MDS documented R40 had received dialysis during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R40 required extensive assistance of one staff member for ADL's. The MDS documented R40 had received dialysis during the look back period. The Urinary Incontinence (involuntary loss of bladder) Care Area Assessment (CAA) dated 04/08/21 documented R40 required extensive assistance with toileting and was frequently incontinent of her bladder. R40's Care Pan dated 02/25/21 documented she had a diagnosis of ESRD with dialysis on Mondays, Wednesdays and Fridays. Review of the EMR under the Orders tab revealed the following orders: Dialysis communication form completed and filed after dialysis, dated 02/09/21. Review of the EMR under the Misc tab from March 1, 2021 to August 3, 2021 revealed dialysis communication sheets dated 03/05/21; 04/19/21 and 06/02/21. On 08/02/21 at 07:55 AM R40 sat in a wheelchair in the common area as she watched TV. Her wheelchair lacked a pressure reducing cushion. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/04/21 at 08:00 AM in an interview, Licensed Nurse (LN) J stated dialysis communication sheets are kept in medical records. LN J stated that communication varied for the dialysis centers. LN stated that he was not sure what communication method was used between the facility and the dialysis center for R40. On 08/02/21 at 02:44 PM in an interview, Administrative Staff B stated all of the dialysis communication sheets that she had received in medical records had been scanned into the EMR under the Misc tab. On 08/05/21 at 03:48 PM in an interview, Administrative Nurse D stated the communication sheet does not always return from the dialysis center. Administrative Nurse D stated the dialysis center does not always cooperate with the nursing facility in returning the communication sheet. The facility Dialysis (Renal), Pre and Post Care policy revised December 2019, documented it was responsibility of the facility for the delivery of care and services to the resident before and after dialysis and directed the resident was assessed before and after transfer to dialysis center. The facility failed to retain dialysis communication sheets and obtain or document vital signs and/or assessments after dialysis for R40 which had the potential for cause adverse consequences related to dialysis.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40688 The facility reported a census of 100 residents. Based on interview and record review, the facility failed to provide Registered Nurse (RN) services for at least eight consecutive hours, seven days a week. Findings included: - Review of the daily nursing staff posting sheets and the facility's Whentowork.com-Published Schedule, provided by the facility as the actual working schedule, revealed the following dates which lacked a RN for eight consecutive hours: 03/21/21-Sunday 04/04/21-Sunday 04/18/21-Sunday 05/09/21-Sunday 07/18/21-Sunday On 08/05/21 at 4:10 PM Administrative Nurse D stated she was aware there were some days the facility did not have the required eight consecutive hours of RN coverage. She stated the administrative nurses, including herself and Administrative Nurse E were frequently added to the schedule in order to provide coverage but there were still occasions the facility did not have the required RN. The facility-provided policy Staffing During Emergency did not contain applicable information. The facility failed to provide a RN for at least eight consecutive hours, seven days a week. This placed all residents in the facility at risk.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40688 The facility reported a census of 100 residents. Based on observation, record review, and interview, the facility failed to post nursing staffing information daily in a prominent place for residents, families, and visitors to view. Findings included: - On 08/02/21 at 07:52 AM, observation revealed the inability to locate the facility's daily staffing posting on any of the units or in any prominent location. On 08/03/21 at 07:25 AM, observation revealed the inability to locate the facility's daily staffing posting on any of the units or in any prominent location. On 08/04/21 at 08:01 AM, observation revealed the inability to locate the facility's daily staffing posting on any of the units or in any prominent location. On 08/05/21 at 01:15 PM the daily staffing posting was observed in a plastic protector posted approximately three feet up on the wall at the business office location in the front entry way. The location was not accessible to all residents, not displayed at a level or location highly visible to residents, family members and visitors. On 08/05/21 at 04:50 PM, Administrative Staff A stated the daily staffing posting was posted outside the marketing office. The facility did not provide a policy on posting of daily staff. The facility failed to post the daily posting of nurse staffing in a prominent place for residents, families, and visitors to view.

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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** 41037 The facility identified a census of 100 residents. The sample included 27 residents. Based on observation, record review, and interviews, the facility failed to provide the care and services related to dementia (progressive mental disorder characterized by failing memory, confusion), for Resident (R) 149, and R21. This deficient practice had the potential to negatively affect the residents' ability to maintain their practicable physical, mental, and psychosocial well-being Findings included: - R149's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented that R149 required limited assistance of one staff member for Activities of Daily Living (ADL's). The Quarterly MDS dated [DATE] documented a BIMS score of 99, a staff interview documented that she had severely impaired cognition. The MDS documented that R149 required extensive assistance of two staff members for ADL's. R149's Cognitive Loss Care Area Assessment (CAA) dated 07/22/20 documented she had a short attention span and would pick up items left out, then move those items to another area . R149's Care Pan dated 07/17/20 documented to engage her in simple, structured activities that avoided demanding tasks . Review of the EMR under Progress Notes documented On 08/10/2o at 05:32 AM documented R149 had hit another resident on the head. The clinical record lacked documentation of the physician had been notified and a person-centered intervention to prevent further potential resident to resident altercation. On 09/01/20 at 08:05 PM documented that she had an altercation with another resident. The clinical record lacked documentation of the physician notification or intervention placed on the care plan to prevent further resident to resident altercations. On 09/10/20 at 06:38 documented R149 was found on the floor, the nurse intervened before another resident kicked her in the face. The clinical record documented the physician, family and director was notified. The Care Plan documented staff would ensure that R149 was not in the proximity of the other resident involved in altercation on 9/11/20, 9/12/20, 9/13/20. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/15/20 at 09:06 AM documented R149 was found in the dining room with another resident stood over her, yelling. R149 stated that the other resident had hit her, physician was notified. On 09/20/20 at 09:43 AM documented that R149 was agitated toward the staff, physician was notified and an order for Haldol (antipsychotic medication class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment testing) and other mental emotional conditions) was requested. The clinical record lacked a person-centered intervention for the staff to utilize for the care of R149. On 10/03/20 at 05:42 PM documented that R149 and another resident had a physical and verbal altercation in the dining room. The physician, Director of Nursing (DON), Durable Power of Attorney (DPOA) for each resident was notified. The Care Plan dated 10/12/20 documented that R149 was transferred to the second floor, the locked unit. On 10/21/20 at 01:26 PM documented that R149 was verbally and physically aggressive toward the staff. The DON and Assistant Director of Nursing (ADON) was notified of the incident, R149 was placed on change of condition monitoring for increased behaviors. Urine analysis (UA) was obtained and was treated with antibiotic (class of medication used to treat bacterial infections) therapy for urinary tract infection dated 10/21/20. On 11/01/20 at 06:29 AM documented R149 was resistive with ADL's and aggressive with staff when attempts made to provide care. The clinical record lacked documentation of the physician was notified and the person-centered attempts made for redirections. On 12/23/20 at 08:31 PM documented that R149 was aggressive toward staff. physician was notified and a one-time order for Haldol 5 milligrams (mgs) was given intermuscular (IM) injection. The clinical record lacked documentation that the DPOA was notified and no care plan intervention was implemented. On 01/10/21 at 01:28 PM documented R149 had a physical altercation with another resident. The Care Plan dated 01/12/21 documented staff to analyze key times, places, circumstances, triggers and what deescalated R149 behaviors and document that information. The Care Plan also documented staff to a make assessment and address the contributing sensory deficits for R149. Staff to assess and anticipate R149 needs which included food, thirst, toileting needs, comfort level, body positioning, pain, etc. The Care Plan also documented the staff monitor and document behavior and attempt ed interventions, to give R149 as many choices as possible about care and activities. On 01/13/21 at 01:58 AM documented R149 was physically aggressive with staff, was unable to redirect her. Physician was notified and an order for one-time injection of Haldol was given. After injection was given IM, R149 had a physical altercation with another resident. The clinical record lacked documentation that the physician was notified of that altercation. On 01/15/21 at 10:33 AM documented the social service had a conversation with R149's DPOA concerning a transfer to hospital for evaluation for behaviors. (continued on next page)

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	175298	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/21 at 09:54 PM documented R149 h been physically aggressive toward the staff when attempts to redirect her while she was wandering. The clinical record lacked the documentation the physician or DPOA was notified and the person-centered interventions utilized when redirected. On 02/04/21 at 07:41 AM documented R149 made verbal threats toward the nursing staff. The Care Plan documented R149 was placed on change of condition for increased behaviors and agitation every shift for three days. On 02/08/21 at 07:22 PM documented R149 was verbally aggressive toward another resident, she was redirected to her room. Interdisciplinary Team (IDT) met and discussed the incident, social service to schedule an urgent care plan meeting to discuss the future of care for R149 related to agitation and aggressive behaviors towards residents and staff. On 02/18/21 at 11:58 AM documented R149 refused to get out of another resident's bed, after three attempts, she became combative toward the staff. The clinical record lacked documentation of physician and DPOA notification. On 02/20/21 at 06:37 PM documented R149 attempted to kick staff. On 02/21/21 at 05:49 AM documented R149 attempted to hit staff and threw water at the staff. On 03/13/21 at 01:21PM documented R149 was physically aggressive toward other residents and staff. The physician was notified and received a one-time order for Haldol IM. DPOA was notified of new order and behavior. At 03:57 PM documented that R149 continued to be aggressive toward staff when attempted to provide ADL S. The clinical record lacked documentation of the person-centered intervention the staff utilized to redirect R149. On 03/27/21 at 01:00 AM documented R149 became aggressive toward staff when ADL care was provided. R149 was left alone in an empty room, no further behavior documented. On 04/11/21 at 02:43 PM documented R149 became verbally aggressive when staff attempted to redirect her as she sat on another resident. On 04/14/21 at 10:23 AM documented R149 was in altercation with another resident struck her in the shoulder. R149 became agitated after the incident, physician, DPOA and DON was notified of altercation. On 05/15/21 at 03:16 PM documented R149 was physically aggressive toward staff, physician was notified. On 07/15/21 at 09:43 AM documented R149 was verbally aggressive toward staff as nurse administered her medications, DON and ADON notified. At 03:02 PM R149 ripped an air conditioner off the wall, she followed a physician off the locked unit. Staff was unable to redirect her back onto the unit, she became physically aggressive. An ambulance was called and she was transported to the hospital for evaluation for psychosis. It took six paramedics/Firefighters to get her on the stretcher they restrained her with gauze as she was being combative with them. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/21 at 11:05 AM in an interview, Certified Nurse's Aide (CNA) O stated she had dementia training over two years ago. CNA O also stated that if a dementia resident had behaviors, she would redirect that resident, change their location and offered a snack or drink. CNA O had not worked with R149 but stated that communication of person-centered interventions is passed on during shift report. 08/05/21 at 11:42 AM in an interview, CNA P stated she had usual dementia training, how to deal with residents with dementia when the have behaviors. CNA P stated that the agency staff did not know the individualized interventions that work for each of the residents on the locked unit for their behaviors. On 08/15/21 at 01:11 PM in an interview, Licensed Nurse (LN) FF stated she had not received any dementia care training since her employment at the facility. LN FF stated b LN FF stated that she had not worked with R149. On 08/05/21 at 12:25 PM in an interview, Administrative Nurse E stated there was no special training for dementia care given. Administrative Nurse E stated residents are separated during an altercation and redirected. She also stated the physician should be notified when a behavior increased in frequency or is continuance. The facility Care of Dementia policy dated March 2020 documented that it is the policy of the facility that all residents will have an individualized plan of care and have the least restrictive approaches to care. Staff are offered specialized training in the care of the dementia population, appropriate approaches to care and managing behaviors. The facility failed to provide appropriate person-centered environment and services needed for R149, who had dementia. This deficient practice affected the resident's ability to maintain her practicable physical, mental, and psychosocial well-being. 42966 - The Diagnoses tab of R21's Electronic Medical Record (EMR) documented diagnoses of dementia without behavioral disturbance, cognitive communication deficit, and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE] documented R21 had a Brief Interview for Mental Status (BIMS) score of six which indicated severe cognitive impairment. R21 had no behaviors during the assessment period. Activity preferences that were very important to R21 were listening to music he liked and going outside to get fresh air when weather was good; activities that were somewhat important to R21 were being around animals, keeping up with the news, doing things with groups of people, doing favorite activities, and participating in religious services or practices. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/14/21 documented R21 was unable to correctly answer questions during the BIMS interview. The Care Plan dated 01/27/17 documented R21 had dementia and directed staff to administer medications as ordered and monitor/document/report to medical doctor (MD) any changes in cognitive function. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 03/19/20, resolved 05/18/21, documented R21 had the potential for lashing out if others got in his space and directed staff to help R21 to maintain safe distance from other residents in common area and to monitor, record, report increased episodes of agitation. The Care Plan dated 03/18/21 documented R21 had the potential to demonstrate physical behaviors related to anger, dementia, and poor impulse control and directed staff to document observed behavior and attempted interventions. The Care Plan dated 01/27/17, documented R21 had little to no involvement in activities due to disinterest and directed his preferred activities were card games, Bingo, outings, arts and crafts, watching movies/TV, trips outside the facility, and socializing. R21 enjoyed watching television in his room and attending happy hour, he occasionally came out of his room into the common area and sit with his peers and drink his coffee. The Documentation Survey Report for March 2021, May 2021 to August 2021 revealed the following days where R21 was provided activities: 03/02/21, 03/04/21, 03/05/21, 03/06/21, 03/08/21, 03/09/21, 03/10/21, 05/28/21, 06/02/21, 06/08/21, 06/10/21, 06/11/21, 06/15/21, 06/16/21, 06/22/21, 06/29/21, 06/30/21, 07/07/21, 07/13/21, 07/14/21, and 07/20/21. On 08/02/21 at 12:30 PM, R21 sat in chair in his room and ate lunch independently. He watched television and conversed with surveyor. Appeared comfortable and without signs of distress or discomfort. On 08/04/21 at 09:38 AM, R21 sat up in bed, head of bed elevated greater than 45 degrees. Breakfast tray on over-the-bed tray table, eyes closed but was eating breakfast independently. On 08/04/21 at 10:30 AM, R21 sat up in bed, head of bed elevated greater than 45 degrees, ate breakfast independently. R21 watched television while he ate, he appeared comfortable and without signs of distress or discomfort. On 08/03/21 at 11:26 AM, Certified Nurse Aide (CNA) N stated she started working at the facility again about three weeks ago but had not received any training on dementia care since she started working again. On 08/03/21 01:43 PM, Administrative Nurse D stated the facility provided a combination of in-person training and computer training with all staff. Dementia training was provided by the speech therapist during and in-service and it was included in the computer training as well. On 08/05/21 at 11:42 AM, CNA P stated she had received dementia training which included how to deal with residents with dementia and when they have behaviors. She stated agency staff did not know the individualized interventions for behaviors that worked for each resident on the locked unit. On 08/05/21 at 12:25 PM, Administrative Nurse E stated there was no special training for dementia care. During altercations, residents were separated and redirected. The physician was notified when a behavior increased in frequency or in continuance. On 08/05/21 at 01:11 PM, Licensed Nurse (LN) FF stated she had not received any dementia training since beginning her employment at the facility within the last 90 days. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/21 at 04:10 PM, Administrative Nurse D stated activities provided coloring books, puzzles, sensory aprons, CDs, and movies for the locked unit residents. The activity director had an activity calendar specifically for that floor. The facility's Care of Dementia policy, last revised March 2020, directed all residents of the facility had an individualized plan of care and have the least restrictive approaches to care. Staff were offered specialized trainings in the care of the dementia population and appropriate approaches to care and managing behaviors. The facility failed to provide care and services related to dementia for R21 who had a history of physical and verbal behaviors towards other residents and staff. This deficient practice created an environment that affected R21's ability to maintain their highest practicable level for physical, mental, and psychosocial well-being.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 100 residents. The sample included 27 residents. Based on observations, record reviews, and interviews, the facility failed to obtain and administer medications as ordered by a physician for Resident (R) 69. This deficient practice had the potential for unwarranted physical complications and less than desired/therapeutic effects of prescribed medications. Findings included: - The Diagnoses tab of R69's Electronic Medical Record (EMR) documented diagnoses of neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), atrial fibrillation (rapid, irregular heartbeat), major depressive disorder (major mood disorder), hypothyroidism (condition characterized by decreased activity of the thyroid gland), gastroesophageal reflux (GERD- backflow of stomach contents to the esophagus), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), and essential hypertension (HTN- high blood pressure). The Admission Minimum Data Set (MDS) dated [DATE], documented R69 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R69 received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medications and diuretic (medication to promote the formation and excretion of urine) medications seven days, and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications six days in the seven-day lookback period. The Psychotropic (drug that affects a person's mental state) Drug Use Care Area Assessment (CAA) dated 07/08/21, documented R69 received psychotropic medications daily for depression and anxiety. The Care Plan dated 07/14/21 documented R69 had GERD and directed facility gave medications as ordered. The Care Plan dated 07/14/21 documented R69 had hypertension and directed facility give antihypertensive (medications used to treat high blood pressure) medications as ordered. The Care Plan dated 07/14/21 documented R69 had potential for mood problem related to little interest or pleasure in doing things and directed facility administered medications as ordered. The Care Plan dated 07/14/21 documented R69 had antidepressant medication use related to depression, poor adjustment to admission and directed facility gave antidepressant medications ordered by physician. The Care Plan dated 07/14/21 documented R69 had antianxiety medication use related to anxiety disorder and directed facility gave antianxiety medications as ordered by physician. The Orders tab of R69's EMR documented the following medication orders: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Colon Herbal Cleanser capsule (medication to support colon health) one capsule one time a day for prophylaxis, start date 07/01/21, discontinued date 07/09/21 Cyanocobalamin (vitamin B-12 [vitamin/supplement]) lozenge 2500 micrograms (mcg) one time a day for supplement, start date 07/01/21, discontinued date 07/09/21 D-Mannose (medication used for urinary tract infections) capsule 500 milligrams (mg) one time a day for supplement, start date 07/01/21, discontinued date 07/09/21 Duloxetine (antidepressant) 90 mg one time a day for depression, start date 07/01/21 Furosemide (diuretic) 40 mg one time a day for supplement, start date 07/01/21 Oscal (vitamin/supplement) 500/200 mg/unit one time a day for supplement, start date 07/01/21 Oxybutynin Chloride (bladder relaxant) Extended Release 15 mg one time a day for bladder spasms, start date 07/01/21 Spironolactone (diuretic) 100 mg one time a day for hypertension/edema, start date 07/01/21 Synthroid (medication to treat hypothyroidism) 300 mcg one time a day for thyroid, start date 07/01/21 Vitamin D3 (vitamin/supplement) 400 unit one time a day for supplement, start date 07/01/21 Whey protein powder (protein supplement) two tablespoons one time a day for supplement, start date 07/01/21, discontinued date 07/09/21 Zinc Sulfate (supplement) 220 mg one time a day for zinc deficiency, start date 07/01/21 Amlodipine (antihypertensive) 5 mg two times a day for HTN, start date 07/01/21 Buspirone hydrochloride (antianxiety) 20 mg two times a day for anxiety, start date 07/01/21 Colchicine (anti-inflammatory used to treat and prevent gout [form of arthritis characterized by severe pain, redness, and tenderness in joints] attacks) 0.6 mg two times a day for prophylaxis for gout flares, start date 07/01/21 Methenamine Hippurate (urinary anti-infective medicine used to treat and prevent urinary tract infections) 1 gram two times a day for prophylaxis, start date 07/01/21 Metoprolol tartrate (antihypertensive) 25 mg two times a day for HTN, start date 07/01/21 Niacin (supplement) 250 mg two times a day for supplement, start date 07/01/21 Potassium Chloride 20 milliequivalent two times a day for supplement, start date 07/01/21 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sulfasalazine (anti-inflammatory used to treat rheumatoid arthritis) 1000 mg two times a day for stomach, start date 07/01/21, discontinued date 07/12/21 Tumeric (supplement) tablet one tablet two times a day for supplement, start date 07/01/21, discontinued date 07/09/21 Baclofen (muscle relaxant) five mg every eight hours for muscle spasm, order date 07/01/21 Gabapentin (nerve pain medication) 300 mg four times a day for neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), start date 07/01/21 Review R69's July and August 2021 Medication Administration Record (MAR) revealed missing administrations for the following medications: Colon Herbal Cleanser not given seven out of seven scheduled administrations Cyanocobalamin not given five out of seven scheduled administrations D-Mannose not given six out of seven scheduled administrations Duloxetine not given 07/05/21, 07/22/21, 07/25/21 - 07/28/21, 07/30/21 - 08/04/21 Furosemide not given 07/3/21, 07/09/21 - 07/19/21, 07/21/21 - 07/23/21, 07/28/21 Oscal not given 07/02/21 - 07/05/21, 07/12/21 - 07/23/21, 07/25/21 - 07/28/21 Oxybutynin not given 07/05/21, 07/22/21, 07/25/21 - 08/04/21 Spironolactone not given 07/22/21, 07/25/21 - 08/02/21, 08/04/21 Levothyroxine not given 07/02/21, 07/12/21, 07/28/21, 07/30/21, 08/03/21, 08/05/21 Vitamin D3 not given 07/12/21 - 07/23/21, 07/25/21 - 07/27/21 Whey Protein Powder not given six out of seven scheduled administrations Zinc not given 07/12/21 - 07/18/21, 07/22/21 Amlodipine not given 07/09/21 evening (PM), 07/10/21 morning (AM), 07/11/21 AM, 07/12/21 AM/PM, 07/13/21 AM, 07/14/21 AM, 07/15/21 AM, 07/16/21 AM, 07/17/21 AM, 07/18/21 AM, 07/19/21 AM/PM, 07/20/21 AM, 07/21/21 AM, 07/22/21 AM, 07/23/21 AM/PM, 07/25/21 AM, 07/26/21 AM/PM, 07/27/21 AM/PM, 07/28/21 AM, 07/29/21 PM, 07/30/21 PM, 07/31/21 AM/PM, 08/01/21 AM, 08/02/21 AM, 08/04/21 AM Buspirone not given 07/19/21 PM, 07/20/21 - 07/23/21 AM, 07/23/21 PM, 07/25/21 - 07/31/21 AM, 07/27/21 PM, 07/30/21 PM, 07/31/21 PM, 08/01/21 AM, 08/02/21 AM/PM, 08/03/21 AM, 08/04/21 AM Colchicine not given 07/05/21 AM/PM, 07/22/21 AM, 07/28/21 - 07/31/21 AM, 07/26/21 - 07/27/21 PM, 07/29/21 PM, 07/31/21 PM, 08/01/21 AM, 08/02/21 - 08/04/21 AM/PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Methenamine Hippurate not given 07/01/21 - 07/02/21 PM, 07/03/21 - 07/07/21 AM, 07/04/21 - 07/06/21 PM, 07/09/21 - 07/16/21 AM, 07/09/21 - 07/10/21 PM, 07/12/21 - 07/15/21 PM, 07/21/21 PM, 07/22/21 AM/PM, 07/27/21 - 07/28/21 AM, 07/31/21 - 08/01/21 AM/PM, 08/02/21 AM Metoprolol tartrate not given 07/03/21 AM, 07/22/21 AM, 07/25/21 - 07/28/21 AM, 07/27/21 PM, 07/30/21 PM, 07/31/21 AM/PM, 08/01/21 AM, 08/02/21 AM, 08/04/21 AM Niacin not given 07/01/21 PM, 07/02/21 AM/PM, 07/03/21 AM, 07/04/21 AM/PM, 07/05/21 AM, 07/22/21 AM, 07/23/21 PM Potassium not given 07/09/21 PM, 07/10/21 AM, 07/12/21 AM/PM, 07/13/21 AM, 07/15/21 AM, 07/22/21 AM, 07/28/21 AM Sulfasalazine not given 18 out of 20 scheduled administrations Tumeric not given 13 out of 14 scheduled administrations Baclofen not given 07/01/21 bedtime (HS), 07/02/21 AM, 07/03/21 PM, 07/12/21 AM/PM, 07/13/21 PM, 07/22/21 PM, 07/26/21 AM, 07/27/21 AM, 07/28/21 PM, 07/29/21 HS, 07/31/21 PM/HS, 08/01/21 PM, 08/02/21 PM/HS, 08/04/21 AM Gabapentin not given 07/01/21 - 07/02/21 HS, 07/22/21 AM/Noon, 07/26/21 AM, 07/27/21 AM/Noon/PM/HS, 07/28/21 AM/Noon, 07/29/21 AM/Noon/HS, 07/30/21 PM/HS, 07/31/21 AM/Noon/PM/HS, 08/01/21 - 08/02/21 Noon On 08/05/21 at 08:44 AM, R69 laid in bed, eyes open. She appeared comfortable and without signs of distress. R69 stated she had not been receiving all her medications and staff told her the medications were stuck at the pharmacy. She stated she had been experiencing a somewhat increase in pain and had been feeling more sad than usual. On 08/05/21 at 01:02 PM, Certified Medication Aide (CMA) R stated new medication orders were ordered by the nurse and the medications were on a cycle from the pharmacy. If a medication was unavailable for administration, she let the charge nurse know and wrote a note in EMR. The charge nurse and Assistant Director of Nursing (ADON) were aware of R69's missing medications. She did not think there was an acceptable amount of time a resident could go without a medication. On 08/05/21 at 03:38 PM, Licensed Nurse (LN) FF stated if a medication was unavailable for administration, she called the pharmacy to see what they needed in order to get the medications. She had contacted the doctor on occasion if pharmacy waited for a script from the doctor. She did not think any amount of time was acceptable to go without a medication. On 08/05/21 at 04:10 PM, Administrative Nurse D stated the facility had contact pharmacy regarding R69's missing medications and pharmacy told the facility the medications were at the facility. She stated the facility searched everywhere in the facility for the medications but were unable to locate. If a medication was unavailable for administration, she expected nursing staff to call the pharmacy and see where the medications were at. Stock medications were available. The doctor was notified if medication administrations were missed and the notification should have been charted. She preferred residents never went without any medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Physician Orders policy, last revised May 2020, directed the facility administered drugs only upon the written order of a person duly licensed and authorized to prescribe such drugs and the charge nurse of director of nursing services placed the order for all prescribed medications. The facility's Medication Ordering and Receiving from Pharmacy policy, last revised August 2014, directed medications and related products were received from the dispensing pharmacy on a timely basis. The facility failed to obtain and administer medications as ordered by a physician for R69. This deficient practice had the risk of unwarranted physical complications and less than desired/therapeutic effects for prescribed medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 100 residents. The sample included 27 residents with five residents for medication review. Based on observation, record review, and interview, the facility failed to ensure the consultant pharmacist (CP) identified irregularities such as medication given outside of physician ordered parameters for blood pressures, no documented blood pressure readings, and physician not being notified of weight increase outside of parameters for resident (R)30; lack of as needed (PRN) medication for constipation given to R11 when no bowel movement for three days, and bloods sugars outside of parameters and the physician not notified for R65.This deficient practice placed the residents at risk for unnecessary medication administration and unwarranted side effects. Findings included: - The electronic medical record (EMR) for R30 documented diagnoses of hypertension (HTN- elevated blood pressure), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (a rapid, irregular heart beat), heart failure (a chronic condition in which the heart does not pump blood as well as it should). The Annual Minimum Date Set (MDS) dated [DATE], documented R30 had a had a Brief Interview for Mental Status (BIMS) of 12 indicating moderately impaired cognition. He required supervision assistance with ADLs. He received a diuretic (a medication used to promote the form and excretion of urine) seven of seven days reviewed. The Quarterly MDS dated [DATE], documented R30 BIMS score of 15 which indicated intact cognition. He required supervision with bathing/showering, was independent with all other Activities of Daily Living (ADLs). He received a diuretic seven of seven days reviewed. The Pressure Ulcer Care Area Assessment (CAA) dated 02/24/21 documented R30 was a. risk for skin injury related to stand by assistance with diuretic use. The Care Plan revised on 05/18/21 documented staff gave all cardiac medication as ordered by the physician and documented the response and any side effects. Staff was to monitor and document/report to physician as PRN and signs and symptoms of CHF such as weight gain. The orders tab in EMR documented the following: Orders dated 02/11/21 to 05/24/21, and 05/25/21 for a daily weight (call physician if weight gain more than two pounds in a day or five pounds in a week), every day shift for weight monitoring. An order dated 05/26/21 for amlodipine besylate (a medication used to treat HTN) five milligrams (mg) by mouth daily for HTN, hold if systolic blood pressure (SBP-measure the pressure in your arteries when your heart beats) is less than 110 or heart rate (HR) less than 60. (continued on next page)

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	175298	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order for losartan potassium (a medication used to treat HTN and CHF) 50 mg by mouth once daily for HTN, hold if SBP is less than 110 or HR less than 60. Orders dated 02/11/21 to 05/24/21 and 05/27/21 for metoprolol tartrate 100 mg by mouth twice daily for HTN, hold if SBP less than 110 or HR less than 60. The Medication Administration Report (MAR) for the month of March 2021, documented that R30 was given metoprolol outside of ordered parameters two out of 60 opportunities. The MAR for April 2021 documented that R30 was given metoprolol outside of ordered parameters five of 62 opportunities. The MAR dated 05/25/21 through 08/03/21, lacked a documented blood pressure (BP) as ordered for R30's BP medications amlodipine besylate, losartan potassium, and metoprolol tartrate. The Progress Notes tab in the EMR for R30 lacked documentation that indicated that the physician was notified when his weight increased more than two pounds in a day or five pounds in a week in the months of March 2021 through July 2021. The Medication Regimen Review (MMR) for March through July 2021 lacked a recommendation or indication that BP readings and weights were reviewed for irregularities by the CP. On 08/08/04/21 at 07:27AM, R30 was awake, dressed, oxygen(O2) nasal canula on, sitting in a chair in his room watching tv, no signs of distress. On 08/03/21 at 11:19AM, R30 was sitting in his recliner in his room drinking coffee and watching tv, had O2 on, pleasant when conversing, no signs of distress. In an interview 08/05/21 at 1:11PM, Licensed Nurse (LN) FF stated, weights are delegated to the CNAs to obtain in the mornings and should be charted by the CNA. She also stated she would notify the physician if she noticed that the weight had increased per the to order. She stated that orders for blood pressure medication should indicate the BP parameters and she would hold the medication if the BP was outside of ordered parameters and make an entry in a progress note. She also stated that the charts are reviewed by the administrative nurses daily. In an interview 08/05/21at 12:11 PM, administrative nurse E, stated she would expect blood pressure medication to have the task added to the order to take BP before the medication was given. She would also expect the nurse to document a progress note stating that the medication was held. Both her and the Director of Nursing (DON) review the MAR and charting daily. She also indicated that the MAR will not flag weights if they have increased more than two pounds in a day or five pounds in a week. In an interview 08/05/21 at 03:48PM Administrative Nurse D stated that al orders come through the Point Click Care system, there are no paper orders, phone orders are received at times and the nurse on duty enters them into the MAR. Both herself and Administrative Nurse E run daily reports that show what new orders have been entered into the MAR. She stated that the CP does check parameters, MMR reviews are sent to her and Administrative Nurse E, they address the nursing issues within a week. She also stated she would like to get the MMR responses back from the physician within a week. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 08/09/21 at 01:31PM CP GG stated she reviews all resident charts remotely once a month. She will look at all medications, orders, diagnoses, assessments, blood sugars and note any irregularities. She created a report and notated anything that was important. She stated she does not check every single resident's chart for blood pressures out of parameters, but usually ones that have had repeated months out of parameter reading, the same with the blood sugars. She will check a resident's weights if there is an order for daily weights if they are on a diuretic and report any irregularities or indicate if the physician should have been notified. The facility policy Medication Regimen Review revised August 2014 documented, the CP performs at lease monthly a review of each resident's medication regiment and identifies irregularities through a variety of sources including: MARs; prescribers' orders, progress notes or prescribers, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic tests results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The facility policy Medication Administration revised 05/2020 documented: medications must be administered in accordance with the written orders of the attending physician; should a drug be withheld, the nurse must initial and circle the MAR space provided for that particular drug; the nurse must enter an explanatory note on the reverse side of the MAR when drugs are withheld. The facility failed to ensure the CP identified R30's BPs were within ordered parameters and medication was held, and to ensure physician was notified when R30's weight increased; which had the potential of unnecessary medication use and unwarranted side effects. 41037 - R11's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), psychosis (any major mental disorder characterized by a gross impairment testing), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R11 required physical assistance of one staff member for bathing during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R11 was totally dependent of one staff member for ADL's and bathing during the look back period. R11's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/17/20 documented she required extensive assistance of one staff member for ADL's. The Medication Administration Record lacked an order for an as needed (PRN) laxative for constipation. Under the Tasks tab for May 2021, it was documented that R11 went five days without a BM on two separate periods of time on 05/10/21 to 05/14/21, and 05/21/21 to 05/25/21. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under the Tasks tab for July 2021 it was documented R11 went seven days without a BM on 07/02/21 to 07/08/21. The clinical record lacked documentation of a PRN laxative being administered for R11 when she had no BM in three days. The Medication Regimen Review (MMR) completed by the CP in the months of March, April, May, June, and July of 2021 lacked any noted irregularities for bowel monitoring (BM). On 08/04/21 at 07:38 AM R11 sat in her wheelchair next to her bed as she watched TV. No behaviors or distress noted. In an interview with Certified Nurse Aide (CNA) N on 08/05/21 at 1:29 PM stated that anybody that changes a resident was responsible for charting BM's. Staff ask independent residents if they had a BM. The EMR alerts staff when a resident has had no BM for three days and they let the nurse or medication aide know. In an interview with Licensed Nurse (LN) FF on 08/05/21 at 3:38 PM stated CNAs chart BM's and the nurse can look daily at alerts on the EMR that will show if a resident has gone three days without a BM. Staff will ask continent residents if they had a BM, if incontinent of bowel then an order for MiraLAX (A medication that helps to promote a BM). The facility doesn't have standing orders that she knows of. In an interview with Administrative Nurse D on 08/05/21 at 3:48 PM stated that herself, and Administrative Nurse E monitor BM's and are alerted daily on the dashboard of the EMR when a resident has gone three days without a BM. Bowel protocols are in place. In an interview with Consultant GG on 08/09/21 at 1:31 PM stated she reviews all resident charts remotely once a month. She will look at all medications, orders, diagnoses, assessments, blood sugars and note any irregularities. She created a report and notated anything that was important. She stated she does not check every single resident's chart irregularities unless they have had repeated instances several months. She does not really look at bowel monitoring. The facility policy Bowel Promotion Monitoring and Management - Guideline dated 01/2016 documented: It is the policy of this facility that- residents are assessed and evaluated to identify risks for constipation; residents receive necessary treatment and monitoring for constipation; interventions are implemented to minimize risks for constipation. The facility failed to ensure that the CP noted irregularities for bowel monitoring for R11 when she went three days or more without having a BM, which had the potential for unnecessary medications and unwarranted side effects. - R65's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS score of 14 which indicated intact cognition. The MDS documented that R65 required limited assistance one staff member for Activities of Daily Living (ADL's). The MDS documented R65 had not received a bath during the look back period. The MDS documented R65 had received insulin (medication to regulate blood sugar), antidepressant (Antidepressant- class of medications used to treat mood disorders and relieve symptoms of depression) medication, and diuretic (medication to promote the formation and excretion of urine) medication for seven days during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R65 required supervision assistance of one staff, member for ADL's. The MDS documented R65 required physical assistance of one staff member for bathing during the look back period. The MDS documented that R65 had received insulin, antidepressant medication, and diuretic medication for seven days and opioid (a class of medication used to treat pain) medication for two days during the look back period. R65's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 12/01/20 documented she self-propelled her wheelchair and she required limited assistance with ADL's. R65's Care Pan dated 11/15/19 directed staff to administer diabetic medication as ordered by physician. Monitor/document any side effects and effectiveness. Review of the EMR under Orders tab revealed: Check blood sugar before meals and at bedtime. Target blood sugar 80-140 before meals and at bedtime related to diabetes mellites (DM) dated 04/26/20. Novolog (Insulin) flex-pen solution pen-injector 100 unit/milliliter (ML), inject 10 units subcutaneously (SQ) before meals for DM dated 08/02/21. Insulin Detemir Solution 100 UNIT/ML Inject 27-unit SQ at bedtime for DM dated 12/05/2020. Review of the physician ordered parameters documented notify on a blood sugar less than (<) 70 and greater than (>), sheet lacked a physician signature or date. Review of the EMR under the Wts/Vitals tab from April 1 2021 to August 3, 2021 documented blood sugars out the physician set parameters: 04/01/21-495; 04/13/21-448; 05/12/21 -435; 06/05/21 -456; 06/26/21 -405; 06/28/21 -431; 07/12/21 -404; 07/21/21 -448. The clinical record lacked documentation that the physician was notified. Review of the Medication Regimen Review (MMR) completed by the CP from August 2020 through July 2021 did not address the out of parameter blood sugars. On 08/05/21 at 09:07 AM R65 sat in her wheelchair next to the bed. She propelled her wheelchair in the room, she was dressed in a tee shirt and incontinent brief, no distress or behaviors noted. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/21 at 12:25 PM in an interview, Licensed Nurse (LN) FF stated the parameters for when the physician should be notified was on the Medication Record (MAR). LN FF stated that she was not sure what was the parameters the physician had set for R65. On 08/05/21 03:48 PM in an interview, Administrative Nurse D stated that Consultant HH had set parameters for out of parameter blood glucose levels and vital signs posted at the nurses station of when he should be notified. In an interview with Consultant GG on 08/09/21 at 1:31PM stated she reviews all resident charts remotely once a month. She will look at all medications, orders, diagnoses, assessments, blood sugars and note any irregularities. She created a report and notated anything that was important. She stated she does not check every single resident's chart irregularities unless they have had repeated instances several months. She does not really look at bowel monitoring. The facility policy Medication Regimen Review revised August 2014 documented, the CP performs at lease monthly a review of each resident's medication regiment and identifies irregularities through a variety of sources including: MARs; prescribers' orders, progress notes or prescribers, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic tests results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The facility failed to ensure the CP recognized and reported of the blood glucose levels out of parameter set by the physician for R65, which placed her at risk of adverse consequences of possible hyperglycemia (greater than normal amount of glucose in the blood).

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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** 41713 The facility identified a census of 100 residents. The sample included 27 residents with five residents for medication review. Based on observation, record review, and interview, the facility failed to ensure that medication was not given outside of physician ordered parameters for blood pressures, failed to ensure staff documented blood pressure readings, and failed to ensure physician was notified of weight increase outside of parameters for resident (R)30; staff further failed to ensure as needed (PRN) medication for constipation was given to R11 when no bowel movement for three days, and failed to notify the physician of bloods sugars outside of ordered parameters for R65. This deficient practice placed the residents at risk for unnecessary medication administration and unwarranted side effects. Findings included: - The electronic medical record (EMR) for R30 documented diagnoses of hypertension (HTN- elevated blood pressure), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (a rapid, irregular heart beat), heart failure (a chronic condition in which the heart does not pump blood as well as it should). The Annual Minimum Date Set (MDS) dated [DATE], documented R30 had a had a Brief Interview for Mental Status (BIMS) of 12 indicating moderately impaired cognition. He required supervision assistance with ADLs. He received a diuretic (a medication used to promote the form and excretion of urine) seven of seven days reviewed. The Quarterly MDS dated [DATE], documented R30 BIMS score of 15 which indicated intact cognition. He required supervision with bathing/showering, was independent with all other Activities of Daily Living (ADLs). He received a diuretic seven of seven days reviewed. The Pressure Ulcer Care Area Assessment (CAA) dated 02/24/21 documented R30 was a. risk for skin injury related to stand by assistance with diuretic use. The Care Plan revised on 05/18/21 documented staff gave all cardiac medication as ordered by the physician and documented the response and any side effects. Staff was to monitor and document/report to physician as PRN and signs and symptoms of CHF such as weight gain. The orders tab in EMR documented the following: Orders dated 02/11/21 to 05/24/21, and 05/25/21 for a daily weight (call physician if weight gain more than two pounds in a day or five pounds in a week), every day shift for weight monitoring. An order dated 05/26/21 for amlodipine besylate (a medication used to treat HTN) five milligrams (mg) by mouth daily for HTN, hold if systolic blood pressure (SBP-measure the pressure in your arteries when your heart beats) is less than 110 or heart rate (HR) less than 60. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order for losartan potassium (a medication used to treat HTN and CHF) 50 mg by mouth once daily for HTN, hold if SBP is less than 110 or HR less than 60. Orders dated 02/11/21 to 05/24/21 and 05/27/21 for metoprolol tartrate 100 mg by mouth twice daily for HTN, hold if SBP less than 110 or HR less than 60. The Medication Administration Report (MAR) for the month of March 2021, documented that R30 was given metoprolol outside of ordered parameters two out of 60 opportunities. The MAR for April 2021 documented that R30 was given metoprolol outside of ordered parameters five of 62 opportunities. The MAR dated 05/25/21 through 08/03/21, lacked a documented blood pressure (BP) as ordered for R30's BP medications amlodipine besylate, losartan potassium, and metoprolol tartrate. The Progress Notes tab in the EMR for R30 lacked documentation that indicated that the physician was notified when his weight increased more than two pounds in a day or five pounds in a week in the months of March 2021 through July 2021. On 08/08/04/21 at 07:27AM, R30 was awake, dressed, oxygen(O2) nasal canula on, sitting in a chair in his room watching tv, no signs of distress. On 08/03/21 at 11:19AM, R30 was sitting in his recliner in his room drinking coffee and watching tv, had O2 on, pleasant when conversing, no signs of distress. In an interview 08/05/21 at 1:11PM, Licensed Nurse (LN) FF stated, weights are delegated to the CNAs to obtain in the mornings and should be charted by the CNA. She also stated she would notify the physician if she noticed that the weight had increased per the to order. She stated that orders for blood pressure medication should indicate the BP parameters and she would hold the medication if the BP was outside of ordered parameters and make an entry in a progress note. She also stated that the charts are reviewed by the administrative nurses daily. In an interview 08/05/21at 12:11 PM, Administrative Nurse, stated she would expect blood pressure medication to have the task added to the order to take BP before the medication was given. She would also expect the nurse to document a progress note stating that the medication was held. Both her and the Director of Nursing (DON) review the MAR and charting daily. She also indicated that the MAR will not flag weights if they have increased more than two pounds in a day or five pounds in a week. In an interview 08/05/21 at 03:48PM Administrative Nurse D stated that al orders come through the Point Click Care system, there are no paper orders, phone orders are received at times and the nurse on duty enters them into the MAR. Both herself and Administrative Nurse E run daily reports that show what new orders have been entered into the MAR. She stated that the CP does check parameters, MMR reviews are sent to her and Administrative Nurse E, they address the nursing issues within a week. She also stated she would like to get the MMR responses back from the physician within a week. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Medication Administration revised 05/2020 documented: medications must be administered in accordance with the written orders of the attending physician; should a drug be withheld, the nurse must initial and circle the MAR space provided for that particular drug; the nurse must enter an explanatory note on the reverse side of the MAR when drugs are withheld. The facility failed to ensure that R30's BPs were within ordered parameters and medication was held, and to ensure physician was notified when R30's weight increased; which had the potential of unnecessary medication use and unwarranted side effects. 41037 - R11's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), psychosis (any major mental disorder characterized by a gross impairment testing), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R11 required physical assistance of one staff member for bathing during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R11 was totally dependent of one staff member for ADL's and bathing during the look back period. R11's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/17/20 documented she required extensive assistance of one staff member for ADL's. The Medication Administration Record lacked an order for an as needed (PRN) laxative for constipation. Under the Tasks tab for May 2021, it was documented that R11 went five days without a BM on two separate periods of time on 05/10/21 to 05/14/21, and 05/21/21 to 05/25/21. Under the Tasks tab for July 2021 it was documented R11 went seven days without a BM on 07/02/21 to 07/08/21. The clinical record lacked documentation of a PRN laxative being administered for R11 when she had no BM in three days. On 08/04/21 at 07:38 AM R11 sat in her wheelchair next to her bed as she watched TV. No behaviors or distress noted. In an interview with Certified Nurse Aide (CNA) N on 08/05/21 at 1:29 PM stated that anybody that changes a resident was responsible for charting BM's. Staff ask independent residents if they had a BM. The EMR alerts staff when a resident has had no BM for three days and they let the nurse or medication aide know. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Licensed Nurse (LN) FF on 08/05/21 at 3:38 PM stated CNAs chart BM's and the nurse can look daily at alerts on the EMR that will show if a resident has gone three days without a BM. Staff will ask continent residents if they had a BM, if incontinent of bowel then an order for MiraLAX (A medication that helps to promote a BM). The facility doesn't have standing orders that she knows of. In an interview with Administrative Nurse D on 08/05/21 at 3:48 PM stated that herself, and Administrative Nurse E monitor BM's and are alerted daily on the dashboard of the EMR when a resident has gone three days without a BM. Bowel protocols are in place. The facility policy Bowel Promotion Monitoring and Management - Guideline dated 01/2016 documented: It is the policy of this facility that- residents are assessed and evaluated to identify risks for constipation; residents receive necessary treatment and monitoring for constipation; interventions are implemented to minimize risks for constipation. The facility failed to ensure that R11 was properly monitored and treated for constipation when she went three days or more without having a BM, which had the potential for unnecessary medications and unwarranted side effects. - R65's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS score of 14 which indicated intact cognition. The MDS documented that R65 required limited assistance one staff member for Activities of Daily Living (ADL's). The MDS documented R65 had not received a bath during the look back period. The MDS documented R65 had received insulin (medication to regulate blood sugar), antidepressant (Antidepressant- class of medications used to treat mood disorders and relieve symptoms of depression) medication, and diuretic (medication to promote the formation and excretion of urine) medication for seven days during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R65 required supervision assistance of one staff, member for ADL's. The MDS documented R65 required physical assistance of one staff member for bathing during the look back period. The MDS documented that R65 had received insulin, antidepressant medication, and diuretic medication for seven days and opioid (a class of medication used to treat pain) medication for two days during the look back period. R65's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 12/01/20 documented she self-propelled her wheelchair and she required limited assistance with ADL's. R65's Care Pan dated 11/15/19 directed staff to administer diabetic medication as ordered by physician. Monitor/document any side effects and effectiveness. Review of the EMR under Orders tab revealed: (continued on next page)

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Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Check blood sugar before meals and at bedtime. Target blood sugar 80-140 before meals and at bedtime related to diabetes mellites (DM) dated 04/26/20. Novolog (Insulin) flex-pen solution pen-injector 100 unit/milliliter (ML), inject 10 units subcutaneously (SQ) before meals for DM dated 08/02/21. Insulin Detemir Solution 100 UNIT/ML Inject 27-unit SQ at bedtime for DM dated 12/05/2020. Review of the physician ordered parameters documented notify on a blood sugar less than (<) 70 and greater than (>), sheet lacked a physician signature or date. Review of the EMR under the Wts/Vitals tab from April 1 2021 to August 3, 2021 documented blood sugars out the physician set parameters: 04/01/21-495; 04/13/21-448; 05/12/21 -435; 06/05/21 -456; 06/26/21 -405; 06/28/21 -431; 07/12/21 -404; 07/21/21 -448. The clinical record lacked documentation that the physician was notified. On 08/05/21 at 09:07 AM R65 sat in her wheelchair next to the bed. She propelled her wheelchair in the room, she was dressed in a tee shirt and incontinent brief, no distress or behaviors noted. On 08/05/21 at 12:25 PM in an interview, Licensed Nurse (LN) FF stated the parameters for when the physician should be notified was on the Medication Record (MAR). LN FF stated that she was not sure what was the parameters the physician had set for R65. On 08/05/21 03:48 PM in an interview, Administrative Nurse D stated that Consultant HH had set parameters for out of parameter blood glucose levels and vital signs posted at the nurses station of when he should be notified. The facility policy Medication Regimen Review revised August 2014 documented, the CP performs at lease monthly a review of each resident's medication regiment and identifies irregularities through a variety of sources including: MARs; prescribers' orders, progress notes or prescribers, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic tests results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The facility failed to ensure staff followed up on blood glucose levels out of parameter set by the physician for R65, which placed her at risk of adverse consequences of possible hyperglycemia (greater than normal amount of glucose in the blood).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42966 The facility identified a census of 100 residents, eight medication carts, and five medication storage rooms. Based on observations, record reviews, and interviews, the facility failed to properly date and store insulin pens (medication used to treat a chronic condition that affected the way the body processed blood sugar); failed to properly date and store a medicated inhaler (device used for administering a medication that was breathed in to relieve asthma or other lung disorders); failed to properly store medications; and failed to discard medicated eye drops, insulin pens/multi-use vial, and medications after expiration date. This deficient practice had the risk for unwarranted physical complications and ineffective treatment for affected residents. Findings included: - On 08/04/21 at 08:03 AM, a medication cart on Kensington unit revealed the following medications: One insulin aspart (Novolog) pen, opened and not dated Two insulin lispro (Humalog) pens, opened and not dated One Levemir insulin pen, opened and not dated Three Lantus insulin pens, opened and not dated One Lantus insulin pen, opened and dated 05/11/21 One Lantus insulin pen, opened and dated 05/01/21 Four Novolog insulin pens, opened and not dated One multi-use Novolog vial, expired on 08/01/21 One sucralfate (antacid- medication used to treat ulcers [an open sore caused by a break in the skin]) tablet outside of original packaging in a medication cup, not labeled with resident name or dosage. One unidentified tablet outside of original packaging in a medication cup, not labeled with medication name, dosage, or resident name On 08/04/21 at 08:17 AM, a medication cart on Bethel unit revealed a medication cup labeled as vitamin D (vitamin/supplement) with several capsules noted in the cup. On 08/04/21 at 08:17 AM the medication storage room on Bethel unit revealed two bottles of vitamin B-12 (vitamin/supplement) pills with expiration date of July 2021. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/04/21 at 08:18 AM, a medication cart on Painted/Bethel unit revealed the following medications: One albuterol inhaler, opened and not dated One bottle of calcium with vitamin D (vitamin/supplement) pills with an expiration date of June 2021. On 08/04/21 at 08:24 AM, a medication cart on Bethel unit revealed one bottle of timolol (medication used to treat glaucoma [condition in which increased pressure in the eye can lead to gradual loss of vision]) eye drops, opened and dated 05/01/21. On 08/04/21 at 08:46 AM, a medication cart on Western unit revealed the following medications: One bottle of betaxolol (medication used to treat glaucoma) eye drops, opened and not dated One Novolog insulin pen dated 07/01/21 One Lantus insulin pen, opened and not dated One Centrum liquid (multivitamin) bottle, expired June 2021 A review of the facility's Medications with Shortened Expiration Dates guide, last revised August 2018, directed insulin aspart (Novolog) pens and multi-use vials expired 28 days once removed from refrigeration; insulin lispro (Humalog) pens expired 28 days once removed from refrigeration; Levemir pens expired 42 days after removed from refrigeration; Lantus pens expired 28 days once removed from refrigeration; and albuterol inhalers expired 12 months after removal from protective pouch. A review of the manufacturer's instructions for Timolol maleate eye drops directed Timolol maleate eye drops were discarded four weeks after first opening. A review of the manufacturer's instructions for betaxolol eye drops directed betaxolol eye drops were discarded four weeks after first opening. On 08/04/21 at 08:18 AM, Administrative Nurse E stated if she found unidentified pills in the medication cart, she discarded them in the drugbuster (drug disposal system) and the expired insulin pens/vials in the sharps container. She stated the facility tracked the dates of the insulin because insulin became ineffective after a certain amount of time. On 08/05/21 at 01:02 PM, Certified Medication Aide (CMA) T stated the CMA and nurse were responsible for checking the medication carts for expired medications and it should have been done daily when there was down time. He stated the facility had a reference guide for when certain medications expired, and all medications were dated once they were opened. On 08/05/21 at 03:38 PM, Licensed Nurse (LN) FF stated it was the nurses' responsibility to check the medication carts/medication rooms for expired medications. She stated insulin pens were good for 30 days once opened and all medications were dated when opened. She was unaware of a reference guide for expiration dates for medications but could ask the Director of Nursing (DON). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 04:10 PM, Administrative Nurse D stated there was a medication policy in the medication room and medication carts for staff to reference, she would have to check on a reference guide for expiration dates for medications. She expected nurses to date insulin pens/vials when removed from refrigeration as they expired after 28 days. The facility's Medication Access and Storage policy, last revised May 2020, directed the facility stored all drugs and biologicals in locked compartments under proper temperature control. The policy directed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures were immediately removed from stock and disposed of according to procedures for medication destruction. The facility's Medication Access and Storage, E kit access policy, last revised October 2019, directed any opened vial without an open date was discarded immediately and replaced with a new vial; any medication that cannot be verified as to the expiration date, either due to not being dated when opened, or unclear shelf life, was discarded immediately and replaced. The facility failed to properly date and store insulin pens; failed to properly date and store a medicated inhaler; failed to properly store medications; and failed to discard medicated eye drops, insulin pens/multi-use vial, and medications after expiration date. This deficient practice had the risk for unwarranted physical complications and ineffective treatment for affected residents.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 40688 The facility reported a census of 100 residents. Based on observation, record review and interviews, the facility failed to provide administration services in a manner that enabled effective and efficient use of resources to attain/maintain each resident's highest practicable physical, mental and psychosocial well-being, as evidenced by the quantity and severity of deficiencies cited on the health resurvey. This had the potential to affect all 100 residents. Findings included: - The facility failed to ensure the residents were free from abuse and neglect. Resident (R) 84, who had a history of aggressive behaviors and striking other residents entered R56's room and struck him in the face multiple times. On another occasion, R84 acted aggressively, then punched R47. Approximately two hours later, R84 hit R71. R21, who had a history of aggressive behaviors grabbed R15 and bent her over, and then on a later date R21 again grabbed R15, by the wrist, and attempted to bend her fingers back. The facility's failure to prevent abuse by R84 and R21 placed those residents on the dementia unit in immediate jeopardy. Further, the facility failed to ensure residents were free from neglect when the facility failed to provide the necessary care as defined in the comprehensive plan for care for R148. R148, who had a history of falls, was required to have hourly checks when in her room alone. The facility failed to provide the hourly check and during the time unattended, R148 obtained injuries consistent with a fall which included an acetabular fracture (pelvis fracture involving the hip joint). The injury necessitated an emergent transfer to an acute care setting where she required a surgical intervention to treat the fracture. (See F600) The facility failed to protect 37 residents on the Kensington unit (secured dementia unit) from abuse and neglect while investigating episodes and/or allegations of abuse and neglect. The facility further failed to fully investigate, identify, and implement interventions in response to instances of resident to resident abuse. Resident (R) 84, who had a history of aggressive behaviors and striking another resident on 10/20/21 entered R56's room on 10/21/20 and struck him in the face multiple times. On another occasion, R84 acted aggressively. Staff failed to implement an immediate intervention, subsequently R84 punched R47. Again, staff failed to implement measures aimed to protect residents and approximately two hours later, R84 hit R71. The facility further failed to implement protective interventions when R21, who had a history of aggressive behaviors grabbed R15 and bent her over, and then later R21 again grabbed R15, by the wrist and attempted to bend her fingers back. The facility's failure to protect residents from resident to resident abuse placed residents on the dementia unit in immediate jeopardy. Further, the facility failed to fully investigate and identify an episode of neglect when the facility failed to complete a thorough investigation and identify the facility's failure to provide the necessary care as defined in the comprehensive plan for care for R148. R148, who had a history of falls, was required to have hourly checks when in her room alone. The facility failed to provide the hourly check and during the time unattended, R148 obtained injuries consistent with a fall which included an acetabular fracture (pelvis fracture involving the hip joint). The facility reviewed the occurrence, placed interventions for a fall but did not address the neglect which occurred when staff failed to provide the necessary hourly checks for R148. This placed R148 at risk for continued neglect. (See F610) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to prevent the potential transmission of infection and provide a sanitary environment for residents when staff lacked proper hand hygiene while providing peri-care to residents, while administering medications, and while passing meal trays to residents in their rooms at meals. The facility to ensure staff transported soiled and clean linen in an appropriate manner to prevent transmission of bacteria. The facility failed to place a clean barrier between the floor and resident care items which touched the floor and failed to sanitize shared equipment in between resident use. The facility further failed to ensure staff wore face masks correctly in order to prevent the spread of Covid-19 (highly contagious viral respiratory disease). This placed the residents at risk for increased infections. (See F880) The facility failed to provide a RN for at least eight consecutive hours, seven days a week. This placed all residents in the facility at risk. (See F727) The facility failed to maintain a safe, clean, homelike environment when the facility failed to secure chemicals, hygiene items, soiled linens and trash out of the reach of the residents. The facility further used the common areas and hallways to store large medical equipment such as wheelchairs, transfer poles, lifts and linen carts which increased the risk for accidents and created an institutionalized environment. The facility failed to maintain sanitary conditions and failed to ensure the area remained free of unpleasant odors. (See F584) The facility failed to ensure an environment free from the risk of injury due to accidents and /or hazards for Resident (R)41, R67, R94, R56 and R69. The facility failed to provide foot pedals on the wheelchair for R41 and failed to ensure two staff members participated in a Hoyer (mechanical lift) transfer. The facility failed to ensure R94's walker was placed within her reach and failed to ensure R56's bed was placed in a low position and call light placed within reach when he was in bed. The facility failed to implement Dycem (nonslip product used to help stabilize or hold objects firmly in place) in R69's wheelchair as directed by her plan of care to prevent her slipping from her wheelchair. These failures placed the five residents at risk for injuries related to falls and other accidents. (See F689) The facility failed to provide consistent bathing for eight dependent residents (R), R8, R11, R65, R79, R50, R69, R88, and R76. This deficient practice had the potential for poor hygiene and low self-esteem for the affected residents. (See F677) The facility failed to properly date and store insulin pens (medication used to treat a chronic condition that affected the way the body processed blood sugar); failed to properly date and store a medicated inhaler (device used for administering a medication that was breathed in to relieve asthma or other lung disorders); failed to properly store medications; and failed to discard medicated eye drops, insulin pens/multi-use vial, and medications after expiration date. This deficient practice had the risk for unwarranted physical complications and ineffective treatment for affected residents. (See F761) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to obtain influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) vaccination and pneumococcal (infection that inflames air sacs in one or both lungs which may fill with fluid) vaccination consents or declinations for Resident (R) 11, R32, R46, R49, R67, R76, and R88; failed to administer pneumococcal vaccination after consent was signed for R15, R21, R30, R34, R50, and R84; failed to obtain COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) vaccination declination for R67; and failed to obtain COVID-19 vaccination consents before administration for R11, R30, and R88. This deficient practice had the risk for unwarranted physical complications and the risk to spread illness among staff and residents, a high-risk population. (See F883) The facility failed to provide the care and services related to dementia (progressive mental disorder characterized by failing memory, confusion) for Resident (R) 149, and R21. This deficient practice had the potential to negatively affect the residents' ability to maintain their practicable physical, mental, and psychosocial well-being. (See F744) The facility failed to identify and maintain R46's eyeglasses which had the potential to affect his overall wellbeing including the potential for decreased communication, and decreased ability to enjoy preferred activities. (See F557) The facility failed to update Point Click Care (PCC- Electronic Medical Record [EMR] system) to accurately reflect the Do Not Resuscitate (DNR) code status for Resident (R) 96 when she readmitted to the facility and failed to ensure a lawful DNR form was maintained by the facility for R46 who had a DNR that was not signed by the physician. This deficient practice had the risk for miscommunication regarding resident's code status and incorrect actions regarding life-saving measures. (See F578) The facility failed to report to law enforcement an allegation of theft of personal property for Resident (R)149 and R11. This placed the residents at risk for ongoing misappropriation. (See F608) The facility failed to report to the State Agency (SA), allegations, occurrences, and/or suspicions of resident-to-resident abuse for Resident(R) 21 and R15. The facility failed to report, within the 24-hour mandated timeframe, an occurrence of neglect for R148 and failed to report two allegations of misappropriation, for R149 and R11. This deficient practice placed the residents at risk for unresolved and ongoing abuse, neglect, and misappropriation. (See F609) The facility failed to provide the resident and his/her representative with written notice of discharge as soon as practical when R49 was sent to an emergency acute facility. (See F623) The facility failed to ensure hospice services were documented and communicated to staff for Resident (R) 34. This deficient practice had the potential for miscommunication between staff and the hospice provider and a potential for missed hospice service opportunities for R34. (See F684) The facility failed to provide timely interventions for the treatment of a stage two (partial thickness wound presenting as a shallow open ulcer with a red or pink wound bed, without slough) pressure injury acquired in the facility for Resident (R) 67. The facility also failed to implement interventions in place to prevent formation, promote healing and prevent recurrence of pressure ulcers for R67 and R40. (See F686) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to retain dialysis communication sheets and obtain or document vital signs and/or assessments after dialysis for Resident (R) 40. This placed R40 at risk for cause adverse consequences related to dialysis. (See F698) The facility failed to obtain and administer medications as ordered by a physician for Resident (R) 69. This deficient practice had the potential for unwarranted physical complications and less than desired/therapeutic effects of prescribed medications. (See F755) The facility failed to ensure the consultant pharmacist (CP) identified irregularities such as medication given outside of physician ordered parameters for blood pressures, no documented blood pressure readings, and physician not being notified of weight increase outside of parameters for resident (R)30; lack of as needed (PRN) medication for constipation given to R11 when no bowel movement for three days, and bloods sugars outside of parameters and the physician not notified for R65.This deficient practice placed the residents at risk for unnecessary medication administration and unwarranted side effects. (See F756) The facility failed to ensure that medication was not given outside of physician ordered parameters for blood pressures, failed to ensure staff documented blood pressure readings, and failed to ensure physician was notified of weight increase outside of parameters for resident (R)30; staff further failed to ensure as needed (PRN) medication for constipation was given to R11 when no bowel movement for three days, and failed to notify the physician of bloods sugars outside of ordered parameters for R65. This deficient practice placed the residents at risk for unnecessary medication administration and unwarranted side effects. (See F757) The facility failed to post the daily posting of nurse staffing in a prominent place for residents, families, and visitors to view. (See F732) The facility failed to provide administration services in a manner that enabled effective and efficient use of resources to attain/maintain each resident's highest practicable physical, mental and psychosocial well-being. This failure had the potential to impact all 100 facility residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40688 The facility identified a census of 100 residents. Based on observation, record review, and interviews, the facility failed to prevent the potential transmission of infection and provide a sanitary environment for residents when staff lacked proper hand hygiene while providing peri-care to residents, while administering medications, and while passing meal trays to residents in their rooms at meals. The facility to ensure staff transported soiled and clean linen in an appropriate manner to prevent transmission of bacteria. The facility failed to place a clean barrier between the floor and resident care items which touched the floor and failed to sanitize shared equipment in between resident use. The facility further failed to ensure staff wore face masks correctly in order to prevent the spread of Covid-19 (highly contagious viral respiratory disease). This placed the residents at risk for increased infections. Findings included: - On 08/02/21 at 07:19 AM Certified Nurse Aid (CNA) P pushed an unidentified resident in a wheelchair down the hallway. CNA P wore her mask down below her chin with her mouth and nose exposed. On 08/02/21 at 07:20 AM the ice chest on Kensington unit was full of ice and the scoop, including the portion touched by staff hands, laid inside the chest touching the ice. Observation on 08/02/21 at 08:05 AM revealed an unidentified nurse sat at the first floor nurses station with no mask on. On 08/02/21 at 09:52 AM R67's air pump connected to his air mattress sat on the floor in his room without a barrier between the floor and the pump. Observation on 08/02/21 at 12:05PM, revealed two unidentified CNAs passed meal trays from a meal cart. Neither CNA did hand hygiene before or after each tray. An unidentified staff member brought a bottle of hand sanitizer for staff to use after multiple trays were passed. On 08/03/21 at 07:19 AM an unidentified male staff member left a resident's room on the Kensington unit carrying unbagged, wadded linens and bedding. He carried the unbagged linens down the hall with gloved hands and the soiled linens touched the front of his shirt. He carried the dirty linens to a cart placed in the hallway, lifted the lid and placed the linens in the cart. He then walked down another hall with the same gloves, retrieved clean linens and bedding from a closet and carried the clean linens and bedding under his arm. The clean linens touched his clothing. On 08/03/21 at 07:27 AM R67's air pump connected to his mattress sat on the floor in his room without a barrier between the floor and the pump. On 08/04/21 at 04:20 PM R67's air pump connected to his mattress sat on the floor in his room without a barrier between the floor and the pump. Observation on 08/04/21 at 10:44 AM revealed an unidentified nurse aide exited room [ROOM NUMBER] with soiled linen outside of a bag, carried the soiled linen down hallway to soiled linen bin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/05/21 at 07:45AM while watching medication administration by Licensed Nurse (LN) KK no hand hygiene was witnessed before or after giving resident their medications. On 08/05/21 at 07:48 AM two staff members transferred R67 with a mechanical lift. After the transfer was completed, one agency staff member washed her hands in the resident's room and then returned the lift to the common area without cleaning or sanitizing the equipment. Observation on 08/05/21 at 08:05AM revealed LN L did not wash hands or use hand sanitizer before she began the procedure of obtaining a resident's blood sugar. LN L donned (put on) gloves and carried the glucometer (instrument used to calculate blood glucose), insulin (hormone which regulates blood sugar) pens and other supplies in her hands. No barrier was placed on the table when the glucometer was placed on table. LN L removed her gloves when finished but did not perform hand hygiene. Observation 08/05/21 at 10:40AM CNA JJ, and CNA LL performed peri-care (cleaning of the genital area) on a resident: donned gloves, shut door, grabbed a new brief, opened calmoseptine packet, lower the head of the bed, emptied catheter into graduated cylinder, doffed gloves, donned new gloves. Peri-care was performed, as well as catheter care performed. Doffed right glove, then donned new right glove. During this process of donning and doffing gloves neither CNAs did not perform any hand hygiene. On 08/05/21 at 11:43 AM CNA P stated the staff had been wearing masks for over a year. She said staff should never be in the resident care areas without a mask. CNA P stated all equipment should be cleaned in between people. Staff usually bagged the dirty linens and the dirty linens should never touch staffs' clothes. CNA P said the clean linens were stored in the linen closets and clean clothes/linens should be covered should never touch staffs' clothes. CNA P stated staff should always wash their hands after caring for a resident even if they wore gloves. In an interview with CNA N on 08/05/21 at 1:29PM stated she did hand hygiene all the time. Before and after going into rooms; anytime she touched something soiled; picking up trays; after before donning/ after doffing gloves. She stated that soiled laundry should be carried away from the body in a bag. In an interview with LN FF 08/05/21 at 3:38 PM stated she would do hand hygiene when hands are soiled; in between working with residents; and between doffing/donning gloves. Soiled laundry should be in a bag carried away from your body. In an interview with Administrative Nurse D on 08/05/21 at 4:10PM stated that she would expect hand hygiene be done between residents and between medications being given. She further stated she expected any shared equipment to be sanitized after each use. Admsinitrative Nurse D stated satff should always transport soiled linens bagged, and neither soiled or clean linens should ever touch the staffs' clothing during transport of the linens. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. Building B. Wing	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Infection Prevention and Control Program revised 01/2021 documented: The Infection Prevention and Control Program (IPCP) is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. It further documented: Prevention of spread of infection is accomplished by use of Standard Precautions (the basic level of infection control that should be used in the care of all patients at all times) and/or other transmission based precautions, appropriate treatment and follow up, and employee work restrictions for illness. Staff and resident education is done to identify risk of infection ad promote practices to decrease risk. The hand hygiene procedures will be followed by staff involved in direct resident contact. The facility policy for IPCP-Linens revised 08/2020 documented: Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the line. Soiled laundry/bedding contaminated with potentially infectious materials must be handled as little as possible and with a minimum of agitation; place contaminated laundry in a bag or container at the location where it was used and do not sort or rinse at the location of use.; place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items; anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment. The facility failed to prevent the potential transmission of infection and provide a sanitary environment for residents when staff lacked proper hand hygiene while providing peri-care to residents, while administering medications, and while passing meal trays to residents in their rooms at meals. The facility to ensure staff transported soiled and clean linen in an appropriate manner to prevent transmission of bacteria. The facility failed to place a clean barrier between the floor and resident care items which touched the floor and failed to sanitize shared equipment in between resident use. The facility further failed to ensure staff wore face masks correctly. This placed the residents at risk for increased infections and transmission of Covid-19.

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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 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. 42966 The facility identified a census of 100 residents. The sample included 27 residents. Based on record reviews and interviews, the facility failed to obtain influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) vaccination and pneumococcal (infection that inflames air sacs in one or both lungs which may fill with fluid) vaccination consents or declinations for Resident (R) 11, R32, R46, R49, R67, R76, and R88; failed to administer pneumococcal vaccination after consent was signed for R15, R21, R30, R34, R50, and R84; failed to obtain COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) vaccination declination for R67; and failed to obtain COVID-19 vaccination consents before administration for R11, R30, and R88. This deficient practice had the risk for unwarranted physical complications and the risk to spread illness among staff and residents, a high-risk population. Findings included: - Influenza and Pneumococcal vaccination consents or declinations were not located in the Electronic Medical Record (EMR) for R11, R32, R46, R67, R76, and R88. Pneumococcal vaccination consents were signed but documentation that vaccination was administered was not found in the EMR for the following residents: R15's representative gave verbal consent by phone on 09/24/20 R21's representative gave verbal consent by phone on 09/24/20 R30 signed consent on 02/11/21 R34's representative gave verbal consent by phone on 09/24/20 R50 signed consent on 03/10/21 R84's representative gave verbal consent by phone on 09/24/20 R67's EMR documented he declined the COVID-19 vaccination, the signed declination was not located in the EMR. COVID-19 vaccinations were given in facility by an outside pharmacy. The following residents received the COVID-19 vaccinations on 01/14/21, the consents located in the EMR were not signed by the resident or the resident's representative: R11, R30, and R88. Review of the listed residents' EMRs revealed no documentation that consent was obtained by residents or residents' representatives. On 08/05/21 at 10:04 AM, Administrative Staff A stated the facility did not have the declination or consents for the influenza and pneumococcal vaccinations for the above residents. (continued on next page)

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	175298	A. Building B. Wing	08/05/2021

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/05/21 at 04:10 PM, Administrative Nurse D stated residents were asked if they wanted to receive the influenza and pneumococcal vaccination on admission and annually. Pharmacy comes monthly for a COVID-19 vaccination clinic, residents are asked on admission if they wanted the COVID-19 vaccination then get placed on the list for the next clinic date. On 08/05/21 at 05:15 PM, Administrative Nurse D stated an outside pharmacy came in to do the first three rounds of COVID-19 vaccinations. She stated social services and marketing would have called the families to obtain verbal consent. She stated she was unable to find a documented note in EMR that verbal consent was obtained for R11, R30, and R88. The facility's Immunizations, Influenza and Pneumococcal policy, last revised January 2021, directed the resident's clinical record/EMR included documentation that indicated at minimum: resident or resident's representative was given information regarding the benefits and potential side effects of influenza immunization and that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility's Immunizations, COVID-19 policy directed the resident's clinical record/EMR included documentation that each resident or resident's representative received education regarding the benefits and potential side effects of the immunization and that the resident either received the COVID-19 immunization or did not receive the COVID-19 immunization due to medical contraindications or refusals. The facility failed to obtain consents or declinations for influenza and pneumococcal vaccinations, failed to administer pneumococcal vaccinations after consents were obtained, failed to obtain declination for COVID-19 vaccination, and failed to obtain/document consent for residents who received the COVID-19 vaccination in facility by an outside pharmacy. This deficient practice had the risk for unwarranted physical complications and the risk to spread illness among staff and residents, a high-risk population.