| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175506 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Andbe Home, Inc | 201 W Crane Street<br>Norton, KS 67654 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>26768<br><br>The facility had a census of 34 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to promote care in a manner to maintain and enhance dignity and respect when staff stood over two residents, Resident (R) 5 and R33, while assisting them to eat. This placed the residents of the facility at risk for impaired dignity.<br><br>Findings included:<br><br>- On 06/10/24 at 11:48 AM, observation revealed Certified Nurse Aide (CNA) O assisted residents in the dining room. CNA O stood up while feeding R5 a few bites of food and then walked over and stood over R33 while assisting him to eat. At 12:18 PM, CNA O sat next to R5 and fed her a few bites of food, then at 12:20 PM, she got up and assisted R33 again. At 12:21 PM, CNA O stood over R5 and gave her a bite of food, walked away from the table, came back, and gave her another bite while standing over her. At 12:23 PM, CNA O stood beside R33 to assist him with a drink and cut up his chicken into smaller pieces. At 12:24 PM CNA O sat by R5 and fed her pureed eggroll. At 12:28 PM, CNA O stood over R33 and fed him a bite or two of cake, then sat by R5 at 12:30 PM, and assisted her again. At 12:38 PM, CNA O stood over R5 again to give her a couple of bites of her meal, and at 12:40 PM, CNA O walked away. At 12:41 PM, a different aide sat with R5 to assist her and at 12:44 PM, the aide took R5 back to her room.<br><br>On 06/11/24 at 08:50 AM, observation revealed R5 sat in her wheelchair at the dining table independently drinking thickened grape juice. The CNA that had been assisting her to eat was helping others. R5 had eaten approximately 50 percent (%) of her pureed breakfast. At 09:00 AM, CNA O stood over R5 and fed her two spoonfuls of sausage, and then some eggs. CNA O then walked over to assist R33 in eating while standing over him. CNA O walked back and assisted R5 again.<br><br>On 06/11/24 at 12:19 PM, observation revealed CNA O sat with R5 and offered a drink of her vanilla shake. CNA O tried to get her to drink the supplement through a straw without success. At 12:38 PM, the dietary staff served her a meal of pureed pork chop, mixed vegetables, sweet potato, and a dessert. Further observation during the meal revealed CNA O got up and assisted R33 with cutting up his food and she stood over him to feed him a bite of food at least three times in between assisting R5 to eat her meal. At 12:51 PM, CNA O went to another table, talked to R25, and offered her assistance before returning to assist R5 again.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/11/24 at 02:04 PM, Dietary Staff BB stated staff should not stand over residents while assisting them to eat.<br><br>On 06/11/24 at 02:27 PM, Administrative Nurse D verified staff were not to stand over residents while feeding them.<br><br>The facility's Assistance with Meals policy, dated 03/2022, stated residents would receive assistance with meals in a manner that meets the individual needs of each resident. Residents who cannot feed themselves would be fed with attention to safety, comfort, and dignity for example: not standing over residents while assisting them to eat.<br><br>The facility failed to promote care in a manner that maintains and enhances dignity and respect when staff stood over R5 and R33 while assisting them to eat. This placed the residents at risk for impaired dignity. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768<br><br>The facility had a census of 34 residents. Based on observation, interview, and record review the facility failed to ensure an environment free from accident hazards when the facility failed to ensure water temperatures in areas with resident access and in Resident (R)18, R17, R25, R1, and R4's rooms remained at a safe temperature when temperatures above 140 degrees Fahrenheit (F) were recorded. This common area and sink were open to the center hallway and accessible to any independently mobile residents. The facility identified seven independently mobile, cognitively impaired residents. This placed twelve residents in immediate jeopardy. The excessively high hot water temperatures of 128-139 degrees F were also recorded in resident room sinks, placing an additional seven residents at risk for burns. The facility failed to identify and implement interventions to prevent R8 from falling which placed the resident at risk of further falls and injuries.<br><br>Findings included:<br><br>- On 06/12/24 at 07:53 AM, observation revealed the water temperature of the center living room/cafe area sink was 152.6 degrees F by surveyor thermometer.<br><br>On 06/12/24 at 08:00 AM, Certified Nurse Aide (CNA) N obtained a facility thermometer and tested the sink at 161 degrees F and verified the temperature was too hot.<br><br>On 06/12/24 at 08:05 AM, an assessment of other resident room sink water temperatures were performed to ascertain the extent of the problem. The following sink water temperatures were found:<br><br>R18's room measured 147 degrees F.<br><br>R4's room measured 143.4 degrees F.<br><br>R17's room measured 139.2 degrees F.<br><br>R7's room measured 138.2 degrees F.<br><br>R20's room measured 129.8 degrees F.<br><br>R9's room measured 129.4 degrees F.<br><br>R8's room measured 129.2 degrees F.<br><br>R2's room measured 129 degrees F.<br><br>R22's room measured 128.5 degrees F.<br><br>R21's room measured 129 degrees F.<br><br>R27's room measured 124.5 degrees F.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | R11's room measured 122.4 degrees F.<br><br>On 06/12/24 at 08:07 AM, Maintenance Staff U stated the water heater that runs the north resident rooms, north shower bathroom, and common area quit working a couple of days ago, 06/09/24. He stated he opened the valve to the laundry heater to go through the resident hot water heater system. After switching the line, he stated he tested the common area but did not document that and did not test the common areas or resident rooms daily while the line was coming from the laundry heater.<br><br>On 06/12/24 at 08:30 AM, Administrative Staff A was informed of the hot water temperatures, and she reported the maintenance person stated he repaired the resident hot water heater on 06/11/24 but had not turned the valve to stop the laundry water heater hot water from going to the resident lines.<br><br>On 06/12/24 at 9:24 AM, R18 stated he had not noted the water to be too hot.<br><br>On 06/12/24 at 09:38 AM, R31 stated she had no problems with hot water being too hot to touch.<br><br>On 06/12/24 at 09:40 AM, R22 stated she had not had any issues with the water being too hot.<br><br>On 06/12/24 at 09:44 AM, R17 stated her bathroom sink water was scalding hot, every morning when the girls (CNAs) get her up, she warns them to be careful the hot water temperature is really hot, because they let it run for a while, and one of them put her hand underneath it and told her she was right it was very hot.<br><br>On 06/12/24 at 09:30 AM, Licensed Nurse (LN) H stated she had not noted any issues with the water being too hot and would inform maintenance if she thought the water temperature too hot. She stated no staff nor residents had complained about the water being too hot.<br><br>On 06/12/24 at 09:50 AM, Administrative Staff A stated the maintenance person informed her he checked water temperatures weekly but did not document them.<br><br>On 06/12/24 at 04:45 PM to 05:00 PM, Re-check of water temperatures indicated the following:<br><br>R17's room measured 149 degrees F.<br><br>R4's room measured 144 degrees F.<br><br>R25's room measured 150.3 degrees F.<br><br>R28's room measured 139.6 degrees F.<br><br>R1's room measured 141 degrees F.<br><br>On 06/12/24 at 05:00 PM, surveyors notified the administrator who checked the temperatures and verified they were still too hot for some of the rooms. She contacted the maintenance person who informed her there was a separate water heater for those rooms. The administrator stated she would ensure the heater was turned down or off immediately.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 06/12/24 at 05:45 PM, Administrative Staff A obtained water temperatures from resident rooms and all temperatures were below 114.2 F.<br><br>The Centers for Medicare and Medicaid (CMS) State Operations Manual (SOM) recorded temperatures at 124 degrees F can cause a third-degree burn (serious burn which affects the outer layer of skin as well as the entire layer beneath and requires immediate medical attention) in three minutes of exposure; temperatures at 127 degrees F can cause third degree burn with one minute of exposure; temperatures at 133 degrees F can cause third-degree burn in 15 seconds of exposure, and water temperatures at 140 degrees F can cause a third-degree burn in five seconds of exposure.<br><br>The facility's Safety of Water Temperatures policy, dated 12/2009, stated the tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Water heaters that service resident rooms, bathrooms, common areas, and shower areas would be set to temperatures of no more than 120 F. Maintenance staff were responsible for checking thermostats and temperature controls in the facility and recording those checks in a maintenance log. Maintenance staff would conduct periodic tap water temperature checks and record the temperatures in a safety log. If hot water temperatures felt excessive to the touch staff were to report that to the immediate supervisor.<br><br>On 06/12/24 at 11:26 AM, Administrative Staff A received the Immediate Jeopardy Template and was informed the facility's failure to ensure the environment remained free of accidents when unsafe hot water temperatures were found in the handwashing sink in R18, R17, R25, R1, and R4's room, placing the five residents in immediate jeopardy related to potential burns from the hot water. Unacceptably hot water was also found in seven other resident rooms placing the twelve affected residents at risk for hot water related burns and/or injuries.<br><br>On 06/13/24 the surveyor verified the following corrective actions to remove the immediacy:<br><br>Maintenance Staff U immediately adjusted the valve on the hot water line so the excessively hot water for the laundry would not go into the residential hot water line which was set at 120 degrees F.<br><br>The water heaters were adjusted to maintain an acceptable level between 105-120 degrees F.<br><br>Education was provided to the maintenance supervisor of the water temperature requirements and documentation of auditing water temperature.<br><br>Accident education was assigned to all staff to be completed by 08:00 AM Monday 06/17/2024.<br><br>Medical Director was notified.<br><br>The scope and severity remained at the level of E, after removal of the immediacy.<br><br>37450<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | - R8's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), adult failure to thrive (includes not doing well, feeling poorly, weight loss, poor self-care that could be seen in elderly individuals), chronic pain, chronic kidney disease, dementia (a progressive mental disorder characterized by failing memory, confusion), muscle weakness, difficulty in walking, and neurocognitive disorder (dysfunction with ability to think and reason).<br><br>R8's Annual Minimum Data Set (MDS), dated [DATE], documented R8 had severe cognitive impairment and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R8 rejected care four to six days of the observation period and had wandering behavior which occurred one to three days of the observation period, and behavioral symptoms that had worsened. R8 had no functional range of motion impairment and used a walker and wheelchair. R8 was independent with bed rolling, sitting on the edge of the bed, and sit-to-stand transfers, and required set-up assistance with walking 10 to 50 feet. The MDS further documented R8 was frequently incontinent of urine and bowel. R8 had two or more non-injury falls and used bed and chair alarms daily. R8 also received scheduled pain medication and took an antianxiety (class of medications that calm and relax people), an antidepressant (class of medications used to treat mood disorders), and an antiplatelet (medication used to slow blood from clotting).<br><br>R8's Care Plan, dated 05/15/24, documented R8 was at risk for falls. The care plan direct staff R8 should have slipper socks on at night and a gripper strip placed beside the bed. The plan directed staff to ensure the alarm was with the resident at all times, functioning properly, plugged in and out of reach. The plan directed staff should strongly encourage the use of a call light, and keep the environment clutter-free with frequently used items within reach. R8 should use a wheelchair to go to meals.<br><br>The Progress Notes and Investigation Notes documented the following falls:<br><br>On 08/18/23 at 07:45 PM, staff were called to R8 rooms and found the resident sitting on the floor next to the bed. R8 reported he was getting up to go to the bathroom. The investigation, dated 08/19/23, documented the care plan was followed and remained appropriate, an exit alarm was in place and functioning. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 08/19/23 at 02:00 AM, R8's alarm sounded, and the resident was sitting on the floor next to the bed. R8 was incontinent of urine and reported he slipped on blankets. Staff assisted the resident to the bathroom. The investigation, dated 08/19/23, documented the care plan was followed and remained appropriate, and the exit alarm was in place and functioning. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 08/31/23 at 05:52 PM, R8's roommate told staff R8 had been leaving the bathroom, had a misstep, and fell . The facility failed to provide an investigation and the care plan lacked new resident-specific intervention related to the fall.<br><br>On 09/10/23 at 11:13 AM, R8 reported heading to the bathroom and R8's feet got caught in the blanket causing the fall. The investigation, dated 09/20/23, documented the care plan was followed and remained appropriate, the exit alarm was in place and functioning. The care plan lacked a new resident-specific intervention related to the fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 10/03/23 at 04:20 AM, staff found R8 on the floor by staff. The note further documented the care plan was followed and the alarm was in place but did not sound when the resident got up. The investigation, dated 10/03/23, documented the care plan was followed and remained appropriate, and the exit alarm was in place and functioning. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 10/03/23 at 06:38 PM, R8 was lowered to the floor by staff while assisting to transfer to a wheelchair and fell on to his knees. The investigation, dated 10/03/23, documented the care plan was followed and remained appropriate, and the exit alarm was in place and functioning. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 11/06/23 at 03:30 AM, R8 had been getting up to use the bathroom and staff saw R8 lying on the floor. R8 reported he hit his head when he fell . The investigation, dated 11/06/23, documented the care plan was followed and remained appropriate, and the exit alarm was in place and functioning. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 11/15/23 at 03:29 PM, the nurse was called to R8 room where R8 fell on to his knees and then lowered himself onto his buttocks on the floor. R8 reported his knees were sore. The investigation, dated 11/15/23, documented the care plan was followed and remained appropriate, and the exit alarm was in place and functioning. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 11/19/23 at 02:16 AM, R8 got up to the bathroom, unplugged the bed alarm, and stood up. R8's roommate reported the fall and that R8 hit his head. The investigation, dated 11/19/23, documented the care plan was followed and remained appropriate, and the exit alarm was in place and functioning. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 12/29/23 at 03:41 PM, R8 was found on his hands and knees on the floor, leaning his head on his roommate's reclining chair. The investigation, dated 12/29/23, documented the care plan was followed and remained appropriate, the exit alarm was in place and functioning and R8 was noncompliant with interventions. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 01/04/24 at 07:00 AM, R8 fell out of bed and the alarm sounded. The investigation, dated 01/04/24, documented the care plan was followed and remained appropriate, the exit alarm was in place and, functioning, and R8 was noncompliant with interventions. The care plan lacked new resident-specific interventions related to the fall.<br><br>On 02/14/24 at 07:10 AM, R8 was sitting on the floor next to his bed. R8 reported he was getting up. The investigation, dated 02/14/24, documented the care plan was followed and remained appropriate, the exit alarm was in place and functioning, and R8 was noncompliant with interventions. A care plan update, dated 02/22/24, documented R8 had a room change to be closer to the nurse's station.<br><br>On 02/20/24 at 07:56 PM, R8 was found on his hands and knees, next to the bed. R8 reported he was getting out of bed. The investigation on 02/20/24 documented the care plan was followed and remained appropriate, the exit alarm was in place and functioning, and R8 was noncompliant with interventions. The care plan lacked new resident-specific interventions related to the fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 06/11/24 at 09:42 PM, observation revealed R8 remained in his room, in bed, leaning over to eat breakfast in bed. R8's bed was flat. R8 ate independently by leaning over to his left side.<br><br>On 06/11/24 at 10:01 AM, Certified Nurse Aide (CNA) M reported to prevent falls for R8, staff were to make sure the alarms were in place. CNA M stated that R8 wore gripper socks and the staff checked on the resident frequently.<br><br>On 06/12/24 at 10:08 AM, Licensed Nurse (LN) H reported staff could look over the care plan for intervention to prevent falls. LN H reported R8 had alarms which staff monitored to ensure function and properly placed. LN H verified R8 had numerous falls and the interventions were not changed and were not effective in preventing falls until R8 was moved closer to the nurse's station.<br><br>On 06/12/24 at 04:02 PM, Administrative Nurse D verified new interventions should have been implemented to prevent falls for R8. Administrative Nurse D verified interventions were not always created or implemented.<br><br>The facility's Falls-Clinical Protocol policy, dated 03/2018, documented the treatment and management the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling and also reconsider the current interventions.<br><br>The facility failed to identify and implement interventions to prevent R8 from falling which placed the resident at risk of further falls and injuries. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358<br><br>The facility had a census of 34 residents. The sample included 12 residents with two reviewed for urinary catheter (a tube inserted into the bladder to drain urine) or urinary tract infection (UTI). Based on observation, record review, and interview, the facility staff failed to ensure sanitary catheter care for Resident (R)11. This placed the resident at risk for infection and catheter-related complications.<br><br>Findings included:<br><br>- R11's Electronic Medical Record (EMR) documented R11 had diagnoses of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying) and urine retention (when your bladder doesn't empty completely or at all).<br><br>R11's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented R11 had a urinary catheter and no UTI during the observation period.<br><br>R11's Care Plan, revised 07/07/24, documented the resident had poor kidney health, and a urinary catheter, and instructed staff to change the catheter monthly per physician order. The care plan instructed staff to soak the graduated cylinder and the catheter holder in vinegar weekly for 20 minutes, get new ones monthly, and record intake and output and provide catheter care every shift.<br><br>The Nurse's Note, dated 01/13/24 documented R11 admitted to the hospital with a diagnosis of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) secondary to UTI.<br><br>A review of R11's clinical record revealed R11 had positive UTIs on 01/13/24, 03/16/24 and 03/27/24.<br><br>On 06/11/24 at 08:27 AM, observation revealed R11 self-propelled down the hall to the dining room with his urinary catheter tubing touching the floor underneath the seat of his wheelchair.<br><br>On 06/11/24 at 11:44 AM, observation revealed R11 self-propelled in a wheelchair down the hall from his room to the dining room with his catheter tubing hitting the back of his shoes and touching the floor, underneath the seat of his wheelchair.<br><br>On 06/11/24 at 02:00 PM, observation revealed R11 self-propelled down the hall from his room with his urinary catheter tubing touching the floor all the way to the dining room.<br><br>On 06/11/24 at 03:26 PM, observation revealed R11 self-propelled from his room into the hall with his catheter tubing touching the floor underneath the seat of his wheelchair. Licensed Nurse (LN) I verified the tubing was touching the floor and stated staff should keep R11's catheter tubing off the floor. LN I retrieved a clip and secured the tubing off the floor.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/12/24 at 01:24 PM, Certified Nurse Aide (CNA) P, entered R11's room and asked if he was ready for her to provide catheter care and the resident replied Yes. CNA P cued R11 to self-propel in a wheelchair into the bathroom, lock the wheelchair brakes, and use the grab bar on the wall to stand by the toilet. CNA P assisted R11 in pulling down his incontinent brief and pants, then applied gloves, and removed the incontinent brief which contained a bowel movement (bm)in it. Further observation revealed CNA P provided catheter care with premoistened wipes, then with the same soiled gloves touched the wheelchair arms and moved it back from the toilet. Further observation revealed CNA P, with the same soiled gloves, placed a new incontinent brief on the resident, touching his pant legs, then CNA P cued R11 to stand and, with the same soiled gloves, pulled up R11's incontinent brief and pants. Observation revealed CNA P, with the same soiled gloves, moved the wheelchair closer to the resident, touching the arms of it and brakes, then removed and discarded the gloves. R11 self-propelled out of the bathroom and CNA P followed him and asked R11 if he needed anything else. CNA P left the room without washing her hands.<br><br>On 06/12/24 at 01:30 PM, CNA P verified she had not changed her gloves after providing perineal care and had not washed her hands prior to leaving the resident's room. CNA P stated she should have.<br><br>On 06/12/24 at 04:10 PM, Administrative Nurse D stated she expected staff to change gloves immediately after providing catheter care and staff should position R11's catheter tubing under his wheelchair to keep it off the floor.<br><br>The facility did not provide a policy regarding how to position a resident's catheter tubing, change gloves, or wash hands when providing catheter care.<br><br>The facility staff failed to ensure staff provided sanitary catheter care for R11. This placed the resident at risk for infection and catheter-related complications. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175506 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Andbe Home, Inc | 201 W Crane Street<br>Norton, KS 67654 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768<br><br>The facility had a census of 34 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure Resident (R) 5 received the required staff assistance with meals in an uninterrupted manner that promoted intake. This deficient practice placed the resident at risk for weight loss.<br><br>Findings included:<br><br>- R5's Electronic Health Record (EHR) documented diagnoses of epilepsy (brain disorder characterized by repeated seizures), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings of sadness), history of cerebral infarction (stroke), and dysphagia (swallowing difficulty).<br><br>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 99 and severely impaired decision-making. The MDS documented R5 required maximal staff assistance for eating. She weighed 93 pounds (lbs.), had weight loss, and was not on a physician-prescribed weight loss regimen.<br><br>R5's Care Plan, dated 05/01/24, directed staff to provide a pureed diet with nectar thick liquids, a 120 milliliter (ml) dietary supplement four times daily, 120 ml juice supplement three times daily, Med-plus supplement as ordered, and encourage 120 ml of water between meals. The care plan directed staff to encourage R5 to eat the high-protein food first, offer menu selections daily, and help mark choices as needed. Staff were to obtain weekly weights.<br><br>The Physician Order, dated 07/20/22, directed staff to assist the resident at all meals to aid in safe swallowing and to increase intake. Provide nectar thick liquids, and extra juice at meals and place water in a six-ounce cup.<br><br>The Nutrition Note by the registered dietician (RD), dated 1/22/24, documented R5's weight was 106 lbs. which was lower than desirable for her age. R5's diet was regular with the meat cut into small bite-size pieces and nectar liquids. R5 ate 26 to 50% of the meals and ate at the assisted table in the main dining room.<br><br>The Nutrition Note, dated 2/5/24, documented a four-ounce Gelatein (gelatin-like protein supplement) was added daily in addition to other multiple interventions. The physician had no new orders other than the Gelatein. R5's weight was 106 lbs., and her current meal intakes were fair, 51 to 75% of meals.<br><br>The Physician Order, dated 02/16/24, directed staff to ensure the resident was up in a wheelchair for meals.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Nutrition Note, dated 04/01/24, documented R5's current weight was 95.8 lbs. and lower than desirable for age. Her diet was regular with meats cut into small bite-size pieces and nectar thick fluids. R5 ate 26 to 50% of meals at the assisted table. Staff tried to help the resident with eating and drinking, but she refused to let them help her. Estimated intakes were meeting estimated nutritional needs, but weight loss was noted. The note suggested increasing the juice supplement to four ounces four times daily, increasing the dietary supplement drink to 120 ml four times daily, and notifying the physician of weight loss. The note suggested if continued weight loss occurred, may consider seeing what R5's family wishes were regarding tube feeding.<br><br>The Nutrition Note, dated 05/20/24, documented R5's current weight was 89.8 lbs. R5's diet changed to pureed with nectar liquids earlier in the month and the resident was allowing staff to assist.<br><br>On 06/10/24 at 11:48 AM, observation revealed Certified Nurse Aide (CNA) O assisted residents with eating in the dining room. CNA O stood up while feeding R5 a few bites of food and then walked over and stood over R33 while assisting him to eat. At 12:18 PM, CNA O sat next to R5 and fed her a few bites of food, then at 12:20 PM, she got up and assisted R33 again. At 12:21 PM, CNA O stood over R5 and gave her a bite of food, walked away from the table, came back, and gave her another bite while standing over her. At 12:23 PM, CNA O stood beside R33 to assist him with a drink and cut up his chicken into smaller pieces. At 12:24 PM CNA O sat by R5 and fed her pureed eggroll. At 12:28 PM, CNA O stood over R33 and fed him a bite or two of cake, then sat by R5 at 12:30 PM, and assisted her again. At 12:38 PM, CNA O stood over R5 again to give her a couple of bites of her meal, and at 12:40 PM, CNA O walked away. At 12:41 PM, a different aide sat with R5 to assist her and at 12:44 PM, the aide took R5 back to her room.<br><br>On 06/11/24 at 08:50 AM, observation revealed R5 sat in her wheelchair at the dining table independently drinking thickened grape juice. The CNA that had been assisting her to eat was helping others. R5 had eaten approximately 50 percent (%) of her pureed breakfast. At 09:00 AM, CNA O stood over R5 and fed her two spoonfuls of sausage, and then some eggs. CNA O then walked over to assist R33 in eating while standing over him. CNA O walked back and assisted R5 again.<br><br>On 06/11/24 at 12:19 PM, observation revealed CNA O sat with R5 and offered a drink of her vanilla shake. CNA O tried to get her to drink the supplement through a straw without success. At 12:38 PM, the dietary staff served her a meal of pureed pork chop, mixed vegetables, sweet potato, and a dessert. Further observation during the meal revealed CNA O got up and assisted R33 with cutting up his food and she stood over him to feed him a bite of food at least three times in between assisting R5 to eat her meal. At 12:51 PM, CNA O went to another table, talked to R25, and offered her assistance before returning to assist R5 again.<br><br>On 06/11/24 at 08:42 AM, Licensed Nurse (LN) J verified staff should not stand over a resident while assisting them to eat.<br><br>On 06/11/24 at 02:04 PM, Dietary Staff BB stated she and the RD monitored weights and would question Administrative Staff D regarding any fluctuations. Dietary Staff BB stated R5 had lost quite a bit of weight prior to getting pureed foods in early May and now ate better. She said R5 also quit spitting out food if the CNAs fed her.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/12/24 at 01:13 PM, LN H stated if R5 was hungry and interested, she ate well though at other times she may not eat much. LN H said R5 sometimes would hold her lips closed when she did not want to eat more.<br><br>On 06/12/24 at 04:03 PM, Administrative Nurse D verified that R5 might eat better some days if a staff person could sit next to her, visit with her, and assist her without interruption. Administrative Nurse D verified staff were not to stand over residents while feeding them.<br><br>The facility's Assistance with Meals policy, dated 03/2022, stated residents would receive assistance with meals in a manner that meets the individual needs of each resident. Residents who cannot feed themselves would be fed with attention to safety, comfort, and dignity for example: not standing over residents while assisting them to eat.<br><br>The facility failed to ensure R5 was assisted with meals in an uninterrupted manner, placing the resident at risk for weight loss. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358<br><br>The facility had a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure adequate pain management was available for Resident (R) 27 who had chronic pain. This placed the resident at risk for unrelieved pain.<br><br>Findings included:<br><br>- R27's Electronic Medical Record (EMR) documented R27 had diagnoses of peripheral (outside, surface, or surrounding area of an organ, other structure, or field of vision) neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet) and absence of left leg below the knee.<br><br>R27's Quarterly Minimum Data Set (MDS), dated [DATE], documented R27 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R27 required moderate staff assistance with personal hygiene and toileting. R39 had lower extremity impairment on one side and was independent with activities of daily living (ADLs) except showering. The MDS documented R27 received scheduled and as-needed (PRN) pain medications, frequently and had pain that rated seven on the pain intensity scale; pain occasionally made it hard for R27 to sleep at night. The MDS documented R27 received an opioid (narcotic) pain medication daily during the observation period.<br><br>R27's Care Plan, revised 03/07/24, documented R27 had frequent, all-over joint pain and phantom leg syndrome( a condition in which patients experience sensations, whether painful or otherwise, in a limb that does not exist). The care plan instructed staff to administer Norco (opioid pain medication) twice a day.<br><br>The Physician Order, dated 03/11/24, instructed staff to administer Norco, one to two tablets 10-325 milligrams (mg), every six hours PRN for pain.<br><br>The Physician Order, dated 03/20/24, instructed staff to administer, Norco, two tablets, 10-325 mg twice a day at 08:00 AM and 08:00 PM.<br><br>The Progress Note, dated 06/10/24 at 01:19 PM, documented the nurse received a fax from the physician with a new order to discontinue R27's PRN Norco and change the scheduled Norco, 10-325 mg, two tablets, to three times a day and schedule them for 08:00 AM, 02:00 PM, and 08:00 PM.<br><br>R27'se Medication Administration Record (MAR) documented the nurse did not administer R27 his Norco, 10-325mg, two tablets on the following dates and times due to it being unavailable:<br><br>06/10/24 at 08:53 AM, 01:05 PM, and 08:00 PM, and on 06/11/24 at 08:00 AM and 10:57 AM.<br><br>The Medication Order Book documented that staff reordered R27's Norco on 06/02/24<br><br>The Progress note, dated 06/09/24 at 02:59 PM, documented the nurse sent a fax to the physician requesting R27's Norco, be changed to three times a day due to R27 having been requesting a PRN dose frequently the last few weeks.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Progress Note, dated 06/11/24 at 04:12 AM, documented the pharmacy did not send R27's Norco, tablets the previous day so R27 had not received his scheduled pain medication that morning. The note documented R27 complained of significant generalized pain and stated he had not slept all night. The note documented the resident statement was true as his light had been on since midnight. R27 requested ibuprofen (pain medication), however there was no standing order for it. The nurse offered Tylenol 1000mg, instead and R27 agreed to take it. Tylenol,1000mg, was administered to R27 as a one-time order at 04:00 AM per standing order for significant pain.<br><br>The Progress Note, dated 06/11/024 at 04:52 AM, documented R27 was out in the hallways roaming in his wheelchair and complaining of pain. R27 was rubbing his leg and grimacing. The nurse assured R27 that the medication would be sorted out as soon as possible and he would be able to have his Norco soon. The note documented R27 stated, I know it's not your fault. I'm just really hurting.<br><br>R27'se Medication Administration Record (MAR) documented the nurse did not administer R27 his Norco, 10-325mg, two tablets on the following dates and times due to it being unavailable:<br><br>06/10/24 at 08:53 AM, 01:05 PM, and 08:00 PM, and on 06/11/24 at 08:00 AM and 10:57 AM.<br><br>On 06/11/24 at 08:04 AM, observation revealed R27 sat in a wheelchair by the nurse's cart at the end of the west hall. R27 told the nurse that he had pain all over. The nurse stated she would call the pharmacy and find out why R27's Norco was not delivered the previous night, as soon as she was done checking his blood sugar.<br><br>On 06/11/24 at 10:00 AM, LN G stated the facility had not received R27's Norco; the physician had increased the Norco the previous day but failed to send it to the pharmacy. LN G stated R27 had not received his Norco since the previous day and he was having pain. LN G stated if staff see that a resident is getting low on medication and the facility still has not received it, staff can call the pharmacy and reorder it again. LN G verified staff had not followed up on the Norco.<br><br>On 06/12/24 at 11:43 AM, Licensed Nurse (LN) G stated staff should reorder residents' medication seven days prior to them running out. LN G verified it was ordered on 06/02/24 and staff did not follow up when it was not delivered.<br><br>On 06/12/24 at 04:10 PM, Administrative Nurse D stated she expected staff to reorder a resident's medication seven days in advance or if the medication was scheduled twice a day, they should order it 14 days in advance. Administrative Nurse D stated if the pharmacy had not delivered the resident's medication after two days, she expected staff to follow up with the pharmacy to see why the facility had not received it.<br><br>Upon request, the facility did not provide a policy regarding reordering medications.<br><br>The facility failed to follow up on R27's Norco medication reorder causing the resident to run out of the medication. This placed the resident at risk for unrelieved pain. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>26768<br><br>The facility had a census of 34 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to dispose of expired medications appropriately. This deficient practice placed residents at risk of receiving ineffective medication.<br><br>Findings included:<br><br>- On 06/10/24 at 08:15 AM, observation revealed the north medication cart contained the following expired medications:<br><br>One bottle of stool softener, 50 milligrams (mg)/8.6 mg senna (laxative), with an expiration date of 12/2023.<br><br>One bottle of calcium complete, 250 mg, plus 2.5 micrograms (mcg) of vitamin D, with an expiration date of 06/2023.<br><br>One bottle of liquid Gerilanta (used to treat the symptoms of too much stomach acid) with an expiration date of 12/2023.<br><br>On 06/10/24 at 08:15 AM, Licensed Nurse (LN) J verified the above expired medications should have been disposed of.<br><br>On 06/10/24 at 08:52 AM, observation revealed the east medication room contained the following expired medications:<br><br>One bottle of extra strength pain relief Tylenol/diphenhydramine (Benadryl), 500/25 mg, with an expiration date of 05/2024.<br><br>One bottle of gas relief, 80 mg, with an expiration date of 02/2024.<br><br>On 06/10/24 at 08:52 AM, LN J verified the above expired medications should have been disposed of.<br><br>On 06/13/24 at 10:10 AM, Administrative Nurse D verified staff were to check the medication carts and rooms for expired medications twice weekly and dispose of expired medications.<br><br>The facility's Medication Labeling and Storage policy, dated 02/2023, stated if the facility had discontinued, outdated medications the staff would contact the dispensing pharmacy for instructions regarding returning or destroying those items.<br><br>The facility failed to dispose of expired medications appropriately, placing residents at risk of receiving ineffective medication. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>32358<br><br>The facility had a census of 34 residents. Based on observation, record review, and interview the facility kitchen staff failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance when dietary staff failed to follow a recipe while preparing the pureed diet. This placed the resident at risk for impaired nutrition.<br><br>Findings included:<br><br>- On 06/11/24 at 11:55, Dietary Staff (DS) CC with Dietary Manager (DM) BB overlooking, stated the facility had one resident who received a pureed diet and five residents who received mechanical soft diets. DS CC placed six three-ounce (oz) pork chops into a steam table pan, transferred them into a blender using tongs, and blended to a mechanically soft consistency. DS CC then transferred an unmeasured amount of mechanical soft pork chop into a steam table pan and placed it on the steam table. Observation revealed DS CC placed the rest of the mechanical soft pork chop in the blender container, added an unmeasured amount of milk, blended the meat to the consistency of mashed potatoes, then transferred the pureed pork chops into a steam table pan, and placed it on the steam table. DS CC said he knew the portions were accurate by estimating the serving size of both the mechanical soft and pureed portions. Observation revealed DS CC placed five three-ounce servings of mixed vegetables into a clean blender container, blended, then added an unmeasured amount of water from the sink and blended to the consistency of pudding.<br><br>On 06/11/24 at 12:00 PM, DS CC verified he had not followed a recipe and stated the facility's dietary department did not have a recipe to follow.<br><br>On 06/11/24 at 12:05 PM, DM BB stated the facility did not have recipes for pureed diets. She stated staff uses different liquids to puree food items and said that for meats, staff should use gravy, and for chicken, staff should use chicken broth. DM BB said if a food item had milk in it, staff should use milk for the liquid, and if for vegetable food items, staff should use the juice from the vegetables to get the right consistency.<br><br>On 06/11/24 at 2:00 PM, DM BB provided a sheet of paper with the batch recipe and stated the pureed recipe was at the bottom of the recipe.<br><br>A review of the recipes for the batch food items revealed the bottom included instructions to kitchen staff describing how to puree food items to the right consistency but did not have a specific recipe for each pureed food item.<br><br>The facility's Following Recipes for Pureed Diets Policy, revised 09/15/17, documented that dietary staff would prepare pureed diets according to the pureed diet recipes provided with the facility menus. Staff would measure the food, liquid, and thickener according to directions.<br><br>The facility kitchen staff failed to follow a recipe when preparing one resident's pureed diet. This placed the residents at risk for impaired nutrition. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358<br><br>The facility had a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the 34 residents who received their meals from the facility's kitchen. This placed the 34 residents at risk for foodborne illness.<br><br>Findings included:<br><br>- On [DATE] at 08:10 AM. observation revealed the nourishment refrigerator/freezer on the right lacked a thermometer. The second refrigerator on the left lacked a thermometer in the freezer and had an expired package of simply steamed cauliflower with an expiration date of [DATE].<br><br>On [DATE] at 08:10 AM, Certified Nurse Aide (CNA) O verified the finding above and stated dietary staff was responsible for placing the thermometers in the nourishment refrigerator/freezers and discarded the simply steam cauliflower.<br><br>On [DATE] at 11:11 AM, observation in the kitchen revealed the following:<br><br>The two-door silver fridge lacked a backup thermometer inside it. The fridge had two unlabeled. undated eggs in a plastic bowl, four slices of undated, unlabeled yellow cheese in plastic wrap. Dietary Staff (DS) CC verified the above findings and discarded the food items.<br><br>An unlabeled, undated powered milk bin, noodle bin, and flour bin.<br><br>Two ceiling vents, one by the entrance door and one above the cupboard had a gray fuzzy substance that flared onto the ceiling approximately four inches.<br><br>On [DATE] at 03:00 PM, observation revealed staff passing uncovered bowls of ice cream on a cart in the facility halls. Certified Nurse Aide (CNA) Q verified the ice cream was uncovered and stated it should be covered.<br><br>On [DATE] at 11:15 AM Dietary Manager (DM) BB verified the issues in the kitchen and stated staff should label and date all food items when placed in the refrigerator and the powered milk bin, noodle bin, and flour bind should be labeled and dated.<br><br>On [DATE] at 02:00 PM, Dietary Manager (DM) BB verified the lack of thermometers in the nourishment room and stated nursing was responsible for obtaining them and placing them in the refrigerator/freezers, then they reported the temperatures to her.<br><br>On [DATE] at 04:10 PM, Administrative Nurse D stated she would expect staff to cover food items when transporting them down the hall and nursing was responsible for placing thermometers in the nourishment center refrigerators.<br><br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility's Cleaning and Sanitation of Dining and Food Service Areas Policy, revised [DATE], documented the food and nutrition services staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule.<br><br>The facility's Food Storage Policy, documented that food would be stored in an area that is clean, dry, and free from contaminants. food would be stored at appropriate temperatures and by methods designed to prevent contamination or cross-contamination. food should be dated as it is placed on the shelves. Every refrigerator must be equipped with an internal thermometer. All foods should be covered, labeled, and dated. frozen food must be maintained at a temperature to keep the food frozen solid. Freezer temperatures should be checked at least two times each day.<br><br>The facility kitchen staff failed to prepare food in accordance with professional standards for food service safety when staff failed to cover bowls of ice cream when transporting them down the hall on the snack cart. The facility failed to place backup thermometers in refrigerators and freezers. This placed the 34 residents who received their food from the facility's kitchen at risk for foodborne illness. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175506 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Andbe Home, Inc | 201 W Crane Street<br>Norton, KS 67654 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>26768<br><br>The facility had a census of 34 residents. Based on interviews and record review the facility failed to implement a water management program for the Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by Legionella). This placed the residents in the facility at risk for Legionella pneumonia<br><br>Findings included:<br><br>- The facility's Water Temperature Check Log documented temperature checks of laundry, kitchen, common areas, and resident rooms weekly. The facility did not have documentation of Legionella preventative measures including risk assessments and identification of potential problem areas and actions taken.<br><br>On 06/10/24 at 03:36 PM, Administrative Staff A stated the city came to the facility yearly and tested the water. The facility uses an osmosis water filtration system for drinking water. She verified the facility lacked a Legionella or waterborne pathogen prevention plan.<br><br>The facility failed to implement a water management program to test and manage waterborne pathogens placing the residents who reside in the facility at risk of contracting Legionella pneumonia. |