STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175077	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Osawatomie	1615 Parker Avenue Osawatomie, KS 66064

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 30 residents with eight residents selected for review, including three residents reviewed for abuse and neglect. Based on observation, record review, and interview, the facility neglected Resident (R)3 when the staff failed to provide incontinence care on 04/09/24 during the eight-hour shift beginning at 02:00 PM when on-coming staff for the 10:00 PM shift was rounding and between 09:50 PM and 10:00 PM found R3 with a urine and bowel soaked brief and a yellow/brown colored ring surrounding the sheet he was on. Additionally, facility failed to prevent verbal abuse to R2 when a staff member spoke to her in an irritated voice telling her We would not be doing this and go to your room when R 2 was yelling up by the nurse's station on 03/05/24. Findings included: - The Medical Diagnosis tab located in the electronic medical record (EMR) for Resident (R)3 included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, and aphasia (condition with disordered or absent language function). The Quarterly Minimum Data Set (MDS) dated [DATE] assessed R3 with a Brief Interview of Mental Status (BIMS) score of seven, indicating severe cognitive impairment. R3 was always incontinent of bowel and bladder and dependent on staff for toileting hygiene. R3 did not transfer on/off a toilet. The Annual MDS dated [DATE] assessed R3 with a BIMS score of two, indicating severe cognitive impairment. He continued to be always incontinent of bowel and bladder, dependent on staff for toileting hygiene, and did not transfer on/off a toilet. The Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], revealed R3 was cognitively impaired, incontinent of urine, had hemiplegia and hemiparesis. The Care Plan dated 01/05/24 revealed R3 was incontinent of bowel and bladder and required total care of one staff for incontinence care. The staff were to check/change R3 every two to three hours and as needed and he often refused to be changed. The Checklist for New Facility Associate Orientation dated 03/20/24 for Certified Nurse Aide (CNA) M, revealed the facility provided Abuse, Neglect, and Exploitation policy training. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA Orientation Checklist dated 03/28/24 revealed R3 completed competency on peri-care. The Daily Clinical Schedule dated 04/09/24 revealed CNA M was assigned on the hall R3 resided on from 02:00 PM to 10:00 PM and CNA N and CNA O scheduled for the 10:00 PM to 06:00 AM shift. The written statement on notebook paper by CNA N dated 04/09/24 revealed she arrived to work at 09:50 PM and began doing walking rounds at which time she noticed R3 saturated with urine and bowel. R3's sheet had a yellow/brown ring around him. CNA N reported her findings to CNA M who responded, Oh I know. CNA M asked CNA N why R3 had not been changed and CNA M said R3 would not let her change him. CNA M asked CNA N if she attempted to get another staff to help change him and CNA N responded back that she was on this hall (R3's hall) so CNA M explained all residents was their responsibility and next time CNA M worked she should ask someone to help and CNA N responded Okay, deal. The email Statement from CNA M to Administrative Staff A dated 04/10/24 revealed CNA M stated a little after 10:00 PM, CNA N told her R3 was soaked and needed to be changed. CNA M went into his room and asked R3 if she could change him, and he said no. CNA M then asked CNA N for help who indicated she would change him, and then she seen CNA O and asked for help who indicated she would change him. CNA M stated it was the end of her shift, so she clocked out and went home. Review of the Progress Notes lacked documentation of R3's condition on 04/09/24 at 09:50 PM. The facility investigation dated 04/15/24, revealed CNA M stated she did not change R3 because she thought residents had to be checked on once per shift. On 04/22/24 at 01:17 PM, observed R3 resting in bed and CNA P and CNA O enter the room. CNA O told R3 they were going to check him and clean him up if needed. CNA O and CNA P provided incontinence cares to R3, who had an episode of urine incontinence. R3 was cooperative while CNA P and CNA O provided cares. On 04/22/24 at 01:28 PM, CNA P stated R3 was to be checked for incontinence every two to three hours. On 04/22/24 at 04:59 PM, CNA N stated on 04/09/24 between 09:50 PM and 10:00 PM, she performed walking rounds and removed R3's blankets to check and see if he had been changed and there was a very visible brown/yellow colored ring on his sheet and his brief was full and she knew he hadn't been changed for some time. CNA N stated she told R3 she would be right back and told CNA M that R3 was an absolute mess and CNA M responded back Oh, I know but he won't let me change him. CNA N asked CNA M if she had asked for help, and she responded she was assigned to this hall. CNA N stated R3 needed approached in a manner where you don't ask if you can change him as he always will say no, even if he needs changed, let him know you were there to check him. On 04/23/24 at 01:37 PM, CNA M stated she worked on 04/09/24 on the 02:00 PM to 10:00 PM shift and was responsible for R3. CNA M stated she did not change R3 because she did not have time and was taking care of other residents. CNA M stated R3 required to be changed every two hours and she did not have time and had forgotten until reminded the next day by Administrative Staff A and Administrative Nurse H. CNA M stated she should have checked him during her shift, but she did not. CNA M stated she went into R3's room after the other shift told her he was soaked but had not been in his room prior to that. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/24 at 01:56 PM, Licensed Nurse (LN) H stated R3 was incontinent of bowel and bladder and required the staff to provide peri-care and roll him back and forth. LN H stated the staff were to check R3 every two hours. On 04/23/25 at 01:58 PM, Administrative Nurse D stated R3 was incontinent of bowel and bladder and expected the staff to check him every two hours and change as needed and as he allowed. Administrative Nurse D stated when she interviewed CNA M, CNA M stated she had checked R3, but he did not want care and she failed to get another staff to attempt and would have expected her to. The facility lacked a policy for check and changing for incontinence. The facility policy Activities of Daily Living dated 07/17/21 revealed quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. The facility policy Area of Focus: Abuse and Neglect dated 11/27/23 revealed the resident has the right to be free from neglect. The facility neglected R3 when they failed to provide incontinence care to him on 04/09/24 during the 02:00 PM to 10:00 PM resulting in R3 having urine and bowel soaked brief and linens with a yellow/brown ring surrounding him. - The Medical Diagnosis tab located in the electronic medical record (EMR) for Resident (R)2 included diagnoses of bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), mild intellectual disabilities, 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), and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE] assessed R2 with a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and fluctuation periods of inattention and disorganized thinking. R3 had other behavioral symptoms not directed towards others one to three days of the assessment period. The Behavioral Symptoms Care Area assessment dated [DATE], revealed R2 was having loud outburst in the hall and commons area which was very upsetting to other residents. The Quarterly MDS dated [DATE], assessed R2 with a BIMS score of nine, indicating moderate cognitive impairment and continued with fluctuating inattention and disorganized thinking, however, not assessed with delusions. R2 had one to three days during the assessment period of verbal behaviors, other behavioral symptoms, and wandering. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 04/18/24, revealed R2 needed assistance for meeting emotional, intellectual, physical, and social needs, was not always able to communicate what was wrong. The facility initiated this portion of the care plan on 01/03/22. The care plan revealed R2 had a behavior problem of inconsolable crying, irrational statements, grandiose ideals, irrational thinking, resistance to cares, attention seeking, periods of agitation, and verbal aggression towards others. The facility initiated this portion of the care plan on 01/29/24. The staff were to anticipate and meet her needs and assist her with activities of daily living (ADL's) when she was frustrated or crying. The facility's In-service dated 01/12/24 revealed CNA LL received education on Resident Rights and Abuse. The Suspension Pending Investigation Form dated 03/05/24 revealed Administrative Staff A witnessed CNA LL state, We are not going to do this today! and R2 should go to her room. The form revealed CNA LL stated this in a loud voice and sounded as though she was irritated with the resident. CNA LL stated to Administrative Staff A she was irritated with R2 and that was why she responded that way. The Care Management note dated 03/05/24 at 05:00 PM by Administrative Staff A revealed at approximately 04:20 PM she witnessed CNA LL tell R2 that she was not going to deal with this today (meaning the crying) and said, You should go to your room. The facility investigation dated 03/15/24 revealed Administrative Staff A witnessed CNA LL on 03/05/24 at approximately 04:20 PM tell R2 she was not going to deal with this today, meaning the crying, and she should go to her room. After pulling CNA LL away from R2, CNA LL told Administrative Staff A she was frustrated and did not want to hear the crying. On 04/22/24 at 03:53 PM, R2 self-propelled her wheelchair out of her room crying loudly, Administrative Staff A intervened, and they both entered R2's room. Administrative Staff A assisted R2 with a few things then propelled R2 out of the room. R2 was calm and had quit crying. On 04/23/24 at 12:32 PM, R2 self-propelled herself out of her room holding her hairbrush and was crying. R2 stopped her wheelchair at the doorway of Administrative Nurse D's office who asked R2 what was wrong. R2 while crying stated I want my hair brushed. Administrative Nurse D told R2 to come on in she would help her and R2 entered the office and stopped crying. On 04/23/24 at 02:50 PM, Administrative Staff A stated on 03/05/24 she was getting ready to leave, it was a little later in the day, and was talking to staff at the front desk. Administrative Staff A stated she heard CNA LL tell R2 she was not going to do this today and CNA LL had her hands in the air and clasped in front of her, but not R2. Administrative Staff A stated she pulled CNA LL immediately away from R2 and had CNA LL sit in her office, where CNA LL said she was overwhelmed with the amount of crying. On 04/24/24 at 10:47 AM, CNA LL stated on 03/05/24 she was getting residents ready for supper, R2 wanted to lie down, and she told R2 she could help her to bed but would have to get up soon for supper. CNA LL stated while talking to the nurse, (could not recall which nurse) R2 came out of her room in absolute hysterics and yelling. CNA LL stated she had to raise her voice because R2 was hard of hearing, and she told R2 she was not going to do this today and to go to her room. CNA LL stated Administrative Staff A intervened and said that was classified as abuse and had me go into her office. CNA LL verified, what she said was not appropriate and she could have handled the situation better. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 01:13 PM Administrative Staff A stated she would have expected CNA LL to use a different approach to R2, with kindness, understanding, and compassion, in a quiet or calm manner, or let Administrative staff A or Administrative Nurse D know if she felt overwhelmed. Administrative Staff A stated with R2 the staff just needed to find the cause of why she would be upset and help her through the moment, it was always something easy. The facility policy Area of Focus: Abuse and Neglect dated 11/27/23 revealed residents must not be subjected to abuse by anyone, including but not limited to staff and staff from other agencies. The resident has the right to be free from abuse. The facility must not use verbal abuse. The facility failed to prevent verbal abuse to R2 when CNA LL used an irritated loud voice telling R2 she was not going to do this and to go to her room.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 30 residents with eight selected for review including three residents reviewed for abuse. Based on observation, record review, and interview, facility staff failed to report neglect of Resident (R)3, on 04/09/24 between 09:50 PM and 10:00 PM when Certified Nurse Aide (CNA) N found R3 with a brief full of urine and bowel and a yellow/brown ring surrounding him on the sheet. Findings included: - The Medical Diagnosis tab located in the electronic medical record (EMR) for Resident (R)3 included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, and aphasia (condition with disordered or absent language function). The Quarterly Minimum Data Set (MDS) dated [DATE] assessed R3 with a Brief Interview of Mental Status (BIMS) score of seven, indicating severe cognitive impairment. R3 was always incontinent of bowel and bladder and dependent on staff for toileting hygiene. R3 did not transfer on/off a toilet. The Annual MDS dated [DATE] assessed R3 with a BIMS score of two, indicating severe cognitive impairment. He continued to be always incontinent of bowel and bladder, dependent on staff for toileting hygiene, and did not transfer on/off a toilet. The Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE] revealed R3 was cognitively impaired, incontinent of urine, and had hemiplegia and hemiparesis. The Care Plan dated 01/05/24 revealed R3 was incontinent of bowel and bladder and required total care of one staff for incontinence care. The staff were to check/change R3 every two to three hours and as needed and often refused to be changed. The Daily Clinical Schedule dated 04/09/24 revealed CNA M assigned on the hall R3 resided on from 02:00 PM to 10:00 PM and CNA N and CNA O scheduled for the 10:00 PM to 06:00 AM shift. The written statement on notebook paper by CNA N dated 04/09/24 revealed she arrived to work at 09:50 PM and began doing walking rounds at which time she noticed R3 saturated with urine and bowel. R3's sheet had a yellow/brown ring around him. CNA N reported her findings to CNA M who responded, Oh I know. CNA M asked CNA N why R3 had not been changed and CNA M said R3 would not let her change him. CNA M asked CNA N if she attempted to get another staff to help change him and CNA N responded back that she was on this hall (R3's hall) so CNA M explained all residents was their responsibility and next time CNA M worked she should ask someone to help and CNA N responded Okay, deal. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The email Statement from CNA M to Administrative Staff A dated 04/10/24 revealed CNA M stated a little after 10:00 PM CNA N told her R3 was soaked and needed to be changed. CNA M went into his room and asked R3 if she could change him, and he said no. CNA M then asked CNA N for help who indicated she would change him, and then she seen CNA O and asked for help who indicated she would change him. CNA M stated it was the end of her shift, so she clocked out and went home. The facility investigation dated 04/15/24, revealed Administrative Nurse D arrived at the facility on 04/10/24 and received a blue card (grievance card) from a CNA staff member dated 04/09/24 at 10:30 PM. The card indicated the CNA arrived at the facility and identified R3 to have bowel and bladder incontinence and a brown ring surrounding him on his bed linens. The CNA failed to notify Administrative Staff A or Administrative Nurse D when the neglect had been identified. On 04/22/24 at 01:17 PM, observed R3 in bed and CNA P and CNA O entered the room. CNA O told R3 they were going to check him and clean him up if needed. CNA O and CNA P provided incontinence cares to R3, who had an episode of urine incontinence. R3 was cooperative while CNA P and CNA O provided cares. On 04/22/24 at 01:28 PM, CNA P stated R3 was to be checked for incontinence every two to three hours. On 04/22/24 at 04:59 PM, CNA N stated on 04/09/24 between 09:50 PM and 10:00 PM, she performed walking rounds and removed R3's blankets to check and see if he had been changed and there was a very visible brown/yellow colored ring on his sheet and his brief was full and she knew he hadn't been changed for some time. CNA N stated she told R3 she would be right back and told CNA M that R3 was an absolute mess and CNA M responded back Oh, I know but he won't let me change him. CNA N asked CNA M if she had asked for help, and she responded she was assigned to this hall. CNA N stated R3 needed approached in a manner where you don't ask if you can change him as he always will say no, even if he needs changed, let him know you were there to check him. On 04/23/24 at 01:37 PM, CNA M stated she worked on 04/09/24 on the 02:00 PM to 10:00 PM shift and was responsible for R3. CNA M stated she did not change R3 because she did not have time and was taking care of other residents. CNA M stated R3 required to be changed every two hours and she did not have time and had forgotten until reminded the next day by Administrative Staff A and Administrative Nurse H. CNA M stated she should have checked him during her shift, but she did not. CNA M stated she went into R3's room after the other shift told her he was soaked but had not been in his room prior to that. On 04/23/24 at 01:56 PM, Licensed Nurse (LN) H stated R3 was incontinent of bowel and bladder and required the staff to provide peri-care and roll him back and forth. LN H stated the staff were to check R3 every two hours. On 04/23/25 at 01:58 PM, Administrative Nurse D stated R3 was incontinent of bowel and bladder and expected the staff to check him every two hours and change as needed and as he allowed. Administrative Nurse D stated when she interviewed CNA M, CNA M stated she had checked R3, but he did not want care and she failed to get another staff to attempt and would have expected her to. Administrative Nurse D stated she expected CNA N to report the neglect at the time of the occurrence. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/24 at 04:18 PM CNA O stated she assisted CNA N on 04/09/24 when arriving for the 10:00 PM to 06:00 AM shift to change R3. R3 had a bowel movement, some was dried on his bottom and appeared he had another movement after that, and his pants had bowel on them as well. CNA N stated R3 had a circle or urine and bowel on the sheet he was laying on. CNA O stated she did not tell the nurse about the neglect, because she thought CNA N might of. The facility policy Area of Focus: Abuse and Neglect dated 11/27/23 revealed the resident has the right to be free from neglect. All alleged violations involving abuse, neglect, exploitation or mistreatment were to be reported immediately, but not later than two hours after the allegation made if the events that cause the allegation involve abuse to the administrator of the facility. The facility failed to report neglect when CNA N and CNA O failed to inform the facility within two hours of the allegation of neglect to R3 when he lacked incontinence care and was found with a full brief of urine and bowel with a yellow/brown ring surrounding him on the sheet on 04/09/24 between 09:50 PM and 10:00 PM.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41121 The facility reported a census of 30 residents with eight residents selected for review, including three residents reviewed for activities of daily living (ADL's). Based on observation, interview, and record review, the facility failed to provide adequate incontinence care to dependent Resident (R)3 on 04/09/24 during the eight-hour shift beginning at 02:00 PM when on-coming staff for the 10:00 PM shift was rounding and between 09:50 PM and 10:00 PM found R3 with a urine and bowel soaked brief and a yellow/brown colored ring surrounding the sheet he was on. Findings included: - The Medical Diagnosis tab located in the electronic medical record (EMR) for Resident (R)3 included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, and aphasia (condition with disordered or absent language function). The Quarterly Minimum Data Set (MDS) dated [DATE] assessed R3 with a Brief Interview of Mental Status (BIMS) score of seven, indicating severe cognitive impairment. R3 was always incontinent of bowel and bladder and dependent on staff for toileting hygiene. R3 did not transfer on/off a toilet. The Annual MDS dated [DATE] assessed R3 with a BIMS score of two, indicating severe cognitive impairment. He continued to be always incontinent of bowel and bladder, dependent on staff for toileting hygiene, and did not transfer on/off a toilet. The Urinary Incontinence and Indwelling Catheter Care Area assessment dated [DATE], revealed R3 was cognitively impaired, incontinent of urine, had hemiplegia and hemiparesis. The Care Plan dated 01/05/24 revealed R3 was incontinent of bowel and bladder and required total care of one staff for incontinence care. The staff were to check/change R3 every two to three hours and as needed and he often refused to be changed. The CNA Orientation Checklist dated 03/28/24 revealed R3 completed competency on peri-care. The Daily Clinical Schedule dated 04/09/24 revealed CNA M was assigned on the hall R3 resided on from 02:00 PM to 10:00 PM and CNA N and CNA O scheduled for the 10:00 PM to 06:00 AM shift. The written statement on notebook paper by CNA N dated 04/09/24 revealed she arrived to work at 09:50 PM and began doing walking rounds at which time she noticed R3 saturated with urine and bowel. R3's sheet had a yellow/brown ring around him. CNA N reported her findings to CNA M who responded, Oh I know. CNA M asked CNA N why R3 had not been changed and CNA M said R3 would not let her change him. CNA M asked CNA N if she attempted to get another staff to help change him and CNA N responded back that she was on this hall (R3's hall) so CNA M explained all residents was their responsibility and next time CNA M worked she should ask someone to help and CNA N responded Okay, deal. (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 - Few	The email Statement from CNA M to Administrative Staff A dated 04/10/24 revealed CNA M stated a little after 10:00 PM, CNA N told her R3 was soaked and needed to be changed. CNA M went into his room and asked R3 if she could change him, and he said no. CNA M then asked CNA N for help who indicated she would change him, and then she seen CNA O and asked for help who indicated she would change him. CNA M stated it was the end of her shift, so she clocked out and went home. Review of the Progress Notes lacked documentation of R3's condition on 04/09/24 at 09:50 PM. The facility investigation dated 04/15/24, revealed CNA M stated she did not change R3 because she thought residents had to be checked on once per shift. On 04/22/24 at 01:17 PM, observed R3 resting in bed and CNA P and CNA O enter the room. CNA O told R3 they were going to check him and clean him up if needed. CNA O and CNA P provided incontinence cares to R3, who had an episode of urine incontinence. R3 was cooperative while CNA P and CNA O provided cares. On 04/22/24 at 01:28 PM, CNA P stated R3 was to be checked for incontinence every two to three hours. On 04/22/24 at 04:59 PM, CNA N stated on 04/09/24 between 09:50 PM and 10:00 PM, she performed walking rounds and removed R3's blankets to check and see if he had been changed and there was a very visible brown/yellow colored ring on his sheet and his brief was full and she knew he hadn't been changed for some time. CNA N stated she told R3 she would be right back and told CNA M that R3 was an absolute mess and CNA M responded back Oh, I know but he won't let me change him. CNA N asked CNA M if she had asked for help, and she responded she was assigned to this hall. CNA N stated R3 needed approached in a manner where you don't ask if you can change him as he always will say no, even if he needs changed, let him know you were there to check him. On 04/23/24 at 01:37 PM, CNA M stated she worked on 04/09/24 on the 02:00 PM to 10:00 PM shift and was responsible for R3. CNA M stated she did not change R3 because she did not have time and was taking care of other residents. CNA M stated R3 required to be changed every two hours and she did not have time and had forgotten until reminded the next day by Administrative Staff A and Administrative Nurse H. CNA M stated she should have checked him during her shift, but she did not. CNA M stated she went into R3's room after the other shift told her he was soaked but had not been in his room prior to that. On 04/23/24 at 01:56 PM, Licensed Nurse (LN) H stated R3 was incontinent of bowel and bladder and required the staff to provide peri-care and roll him back and forth. LN H stated the staff were to check R3 every two hours. On 04/23/25 at 01:58 PM, Administrative Nurse D stated R3 was incontinent of bowel and bladder and expected the staff to check him every two hours and change as needed and as he allowed. Administrative Nurse D stated when she interviewed CNA M, CNA M stated she had checked R3, but he did not want care and she failed to get another staff to attempt and would have expected her to. The facility lacked a policy for check and changing for incontinence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175077	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Osawatomie	1615 Parker Avenue Osawatomie, KS 66064

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Activities of Daily Living dated 07/17/21 revealed quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. The facility failed to provide incontinence care to R3 on 04/09/24 during the 02:00 PM to 10:00 PM resulting in R3 having urine and bowel soaked brief and linens with a yellow/brown ring surrounding him.