STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175145	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Retirement Community	700 W 7th Street Overbrook, KS 66524

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 49 residents. The sample included 13 residents with one resident reviewed for discharge. Based on observation, record review, and interview, the facility failed to provide Resident (R)25 with written information regarding the facility's bed hold policy when they were transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility. Findings included: - R25's Electronic Medical Record (EMR) recorded diagnoses of pleural effusion (abnormal accumulation of fluid in the lungs), cellulitis (a bacterial infection that affects the skin and tissues beneath it), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and hypertension (HTN-elevated blood pressure). R25's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R25 had severely impaired cognition. The MDS recorded R25 required staff assistance with most activities of daily living (ADL). The Activities of Daily Living Care Area Assessment (CAA), dated 08/27/24, recorded R25 had a significant change in care needs and was less talkative and mumbled at times. R25 had decreased intake with weight loss and a cellulitis infection. The CAA documented R25 has had a gradual decline in mobility, incontinence, and pain; she was sleeping more, and using a full-body lift. R25's Care Plan, dated 12/04/24 recorded R25 chose hospice due to a diagnosis of hypertensive heart disease and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The care plan documented that staff would observe and report signs of localized infection, pain, redness, swelling, tenderness, loss of function, or heat at the infected area. The care plan documented that staff would watch for nonverbal signs of pain, increased restlessness, agitation, and grimacing. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note dated 08/23/24, at 10:56 AM, documented the nurse went into the resident's room that morning to administer morning medications. R25 was very red, flushed in the face, and sweating. The nurse assessed the cellulitis in R25's abdominal folds and noted the cellulitis had spread to her left leg and across her abdomen. The resident was in a lot of pain and staff administered pain medication. The nurse spoke with the resident's representative and the representative requested the resident be sent to the hospital for evaluation. At 10:48 AM the resident was transported to the hospital. The Nurses Note dated 08/25/24 at 01:39 PM documented the resident was admitted to the hospital. R25's clinical record lacked evidence a copy of the bed hold policy was provided to the resident and the facility was unable to provide evidence upon request. On 12/11/24 at 09:15 AM, Social Service X verified the facility had not provided the resident or her representative the bed hold notice when R25 was transferred and admitted to the hospital on 08/23/24. The facility's Bed Hold policy, undated, documented before the facility transfers a resident to the hospital or the resident goes on therapeutic leave, the facility would provide information to the resident and/or resident representative that specifies the duration of the state bed hold policy during which the resident is permitted to return and resume residency in the facility; the reserve bed payment policy in the state plan; the facilities' policies regarding bed-hold period, which are consistent with the law permitting the resident to return. The policy documented at the time of admission, the resident and/or representative/legal guardian and interested family member would be provided verbal and written copies of the bed hold policy, and signed confirmation of receipt of the policy would be maintained in the resident's clinical record. Facility staff would follow up with the resident/representative if confirmation is not received in three business days. The facility staff would call the resident/representative for phone confirmation of receipt and a reminder to return the form to the facility at the first possible opportunity and phone confirmation of receipt would be documented in the resident's clinical record. The facility failed to provide R25 with a copy of the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.

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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	Provide and implement an infection prevention and control program. 37450 The facility had a census of 49 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to handle all soiled linen as contaminated and use appropriate barriers while sorting soiled laundry to prevent contamination of clean linens. This placed the residents at increased risk for infectious diseases. Findings included: - On 12/10/24 at 02:38 PM, observation of the Laundry area with Housekeeping U revealed two commercial washing machines and dryers. The area was divided into a soiled and clean area. The soiled side had the washing machine and the clean side had the dryer and folding areas. Housekeeping U reported a company tests the water temperatures and the dispensing machine for correct settings. Housekeeping U stated if there was an infectious process happening in the building, she would receive this information in a verbal report. Housekeeping U reported she only used gloves to sort the soiled laundry and did not don a gown or apron. She said she tried not to let any soiled laundry touch her clothing but could understand the possible transfer of soiled or infectious materials from her clothing, after sorting the soiled linens, to the clean laundry while sorting and folding. On 12/10/24 at 02:55 PM, Administrative Nurse D stated the laundry personnel should wear a barrier of some type while sorting through soiled laundry. The facility's undated Laundry Protocols policy documented it was the policy of the facility to prevent the spread of infection by appropriate separation, collection, laundry, and storage of laundry. Facility staff will handle, store, process, and transport linens in a method to prevent the spread of infection. The laundry room will be equipped with a handwashing sink and alcohol gel dispensers in addition to appropriate supplies of personal protective equipment including but not limited to impervious gowns and gloves of appropriate sizes. The facility failed to handle all soiled linens as contaminated and use appropriate barriers while sorting soiled laundry. This placed the residents at risk for infectious diseases.