STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175173	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Resort	2700 W 30th Street Emporia, KS 66801

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	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** 28560 The facility reported a census of 55 residents with three residents selected for review. Based on observation, interview and record review, the facility failed to provide care and services for activity of daily living for one dependent Resident (R)1. related to proper fingernail trimming/hygiene. Findings included: - Review of Resident (R)1's medical record revealed diagnoses that included urinary incontinence and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Admission Minimum Data Set (MDS) dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The resident was dependent on staff for all Activities of Daily Living (ADL). The ADL Functional/ Rehabilitation Care Area Assessment (CAA), dated 12/20/23, did not trigger. The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of two, which indicated severe cognitive impairment. The resident was dependent on staff for ADL's. The Care Plan reviewed 09/24/24, instructed staff to provide bathing and trim nails. Observation, on 09/24/24 at 01:05 PM, revealed the resident seated in his room in his wheelchair. The resident's fingernails on both hands contained a brown substance along the edges and underneath the fingernails and the fingernails were approximately one eight inch in length. A family member stated the resident scratched at a rash on his body and had fragile skin. Observation on 09/25/24 at 07:15 AM, revealed the resident positioned in bed. Certified Nurse Aide (CNA)N provided morning care to the resident. Certified Medication Aide (CMA) O assisted CNA N to transfer the resident into his wheelchair with the use of a mechanical lift. CNA N confirmed the resident's nails had a brown substance underneath them should be trimmed and cleaned on his bath days. CNA N stated the resident at times he could become uncooperative with cares. CNA N stated he was most cooperative when family was present. Interview on 09/25/24 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to maintain the resident's nails in a trimmed and cleaned manner. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Dignity reviewed 02/2023, instructed staff to provide grooming to resident's as they wish to be groomed which included clean and clipped nails. The facility failed to provide care and services for activity of daily living for one dependent Resident (R)1. related to proper fingernail trimming/hygiene.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 55 residents with three residents selected for review, which included three residents reviewed for skin issues. Based on observation, interview, and record review, the facility failed to ensure staff applied one Resident (R)2's compression wraps in a manner to prevent potential skin damage. Findings included: - Review of Resident (R)2's medical record revealed diagnoses that included lymphedema (swelling caused by accumulation of lymph), chronic venous hypertension (elevated pressure in the veins) and venous ulcer (a wound caused by impaired blood flow) of the left lower extremity. The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The resident was at risk for pressure ulcer development and had one stage two pressure ulcer (an open wound that can appear as a blister abrasion or shallow crater in the skin .and one venous ulcer. The Pressure Ulcer Care Area Assessment (CAA), dated 02/04/24, assessed the resident had impaired skin integrity due to pressure wound, stasis ulcer (venous ulcer), incontinence and R2 required assistance to reposition/transfer and use a wheelchair for mobility. The Care Plan, reviewed 07/22/24, instructed staff the resident received treatment for chronic wounds and to monitor for signs of infection or deterioration. A Physician's Order dated 09/20/24, instructed staff to apply a single layer of Tubigrip (a fabric sleeve that provides even pressure distribution) and light ace wrap (a strip of elastic cloth to wrap around a body part to provide gentle pressure to reduce swelling) to bilateral (both) lower extremities and heel protector boots at all times. Observation, on 09/25/24 at 08:30 AM, revealed the resident positioned in bed with offloading boots on bilaterally and compression wraps to bilateral lower extremities. Observation, on 09/25/24 at 10:08 AM, revealed the resident seated in her wheelchair in her room with bilateral offloading boots on and compression wraps to bilateral lower extremities. Administrative Nurse D removed the offloading boot from the resident's right lower extremity and proceeded to remove the Tubigrip and unwrapped the ace wrap. The resident stated there was a painful area just below her right knee that persisted all night. Administrative Nurse D measured a 14-centimeter (cm) red slow blanching (time it takes tissue to recover to normal color upon touch) red indented ridged area around the anterior (inner aspect) of her upper calf area along the edge of the ace wrap and a 12 cm less reddened area around the lateral side outer aspect of her upper calf area. Administrative Nurse D stated she would notify the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 10:20 AM, with the resident revealed she notified the charge nurse during the night of her discomfort in her right lower extremity, but staff did not examine her leg or adjust the pressure bandage. Interview on 09/25/24 at 10:20 AM, with Administrative Nurse D, revealed she would expect staff to examine the residents' extremities and adjust the compression devices to relieve the pain and redness. The facility policy Skin Integrity revised 05/2023, instructed staff the facility must ensure that a resident receives care consistent with professional standards of practice to prevent pressure ulcers. The facility failed to ensure staff maintained the resident's compression wrap to her right lower extremity in a manner to prevent discomfort and undue pressure areas as per standards of practice.