| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175202 | A. Building<br>B. Wing | 06/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colby Operator, LLC | 105 East College Drive<br>Colby, KS 67701 |

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents, with one reviewed for dignity and respect. Based on observation, record review, and interview, the facility failed to promote dignity for one resident, Resident (R) 3, who was left uncovered in bed with only an incontinence brief on. This placed R3 at risk for impaired dignity.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R3 documented diagnoses of retention of urine (lack of ability to urinate and empty the bladder), diabetes mellitus (DM - when the body cannot use glucose, no enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), benign prostatic hyperpiesia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), and peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).<br><br>The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had severely impaired cognition. R3 was dependent upon staff for toileting hygiene, showers, dressing, personal hygiene, mobility, and transfers. R3 was always incontinent of bowel and had a catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid).<br><br>R3's Care Plan, dated 05/28/25, initiated on 02/09/21, documented R3 required two staff for bed mobility, and one staff for personal hygiene. The update, dated 03/24/23, documented R3 had a catheter and directed staff to check tubing for kinks often throughout every shift, monitor and document intake and output as per facility policy.<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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/10/25 at 08:15 AM, observation revealed Certified Nurse Aide (CNA) N removed R3's blanket off the bed and revealed R3 only had on an incontinence brief. CNA M wiped R3's face with a wet washcloth and swabbed his mouth. CNA M untaped R3's brief and noticed there were no wipes for her to perform catheter care. CNA M asked CNA N to go and get her some wipes so that she could do R3's catheter care. CNA M did not cover R3, and he laid in bed naked while CNA N left the room to get the wipes. R3 stated, You guys gonna cover me up? I'm freezing! CNA M did not cover up R3; she stood by his bed and waited for CNA N to bring more wipes. After CNA N brought in the wipes, CNA M performed catheter and other personal care. After they provided personal care, a clean attend was placed under him, and he asked that it not be fastened but left open. R3 was repositioned on his left side, and then he was covered up with a clean blanket.<br><br>On 06/11/25 at 08:30 AM, CNA M stated she should have covered him up while waiting for the wipes.<br><br>On 06/10/25 at 02:53 PM, Administrative Nurse D stated that R3 should not have been left uncovered while there were no cares being provided, and she would reeducate staff on dignity and respect for the resident.<br><br>The facility's Resident Rights policy, dated 12/24, documented that the facility would make every effort to assist each resident in exercising his/her rights to ensure that the resident was always treated with kindness, respect, and dignity. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan with resident-centered interventions for Activities of Daily Living (ADL) for one resident, resident (R) 25. This placed the resident at risk for unmet care needs.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R25 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness).<br><br>R25's Annual Minimum Data Set (MDS), dated [DATE], documented R25 had moderately impaired cognition. R25 required set-up assistance with oral hygiene, dressing, and personal hygiene. R25 was independent with mobility, transfers, and ambulation. R25 had no behaviors or rejection of care and felt it was very important to choose a bath, shower, or bed bath.<br><br>The ADL Care Area Assessment (CAA), dated 09/02/24, documented R25 had a risk for potential alterations in his ADL function related to his diagnoses. The CAA further documented that staff would put interventions into place for his ADL status.<br><br>R25's Quarterly MDS, dated 03/21/25, documented R25 had severely impaired cognition. R25 required supervision with showers, and independent with dressing, oral hygiene, mobility, transfers, and ambulation. R25 had no behaviors or rejection of care.<br><br>R25's Care Plan, dated 03/12/25, lacked a care area with interventions for ADLs.<br><br>The April 2025 Shower Sheets documented R25 had not received a shower during the following days:<br><br>04/01/25 - 04/12/25 (12 days)<br><br>The April Shower Sheets documented R25 refused a shower on 04/09/25.<br><br>The May and June 2025 Shower Sheets, documented R25 had not received a shower during the following days:<br><br>05/09/25 - 05/25/25 (17 days)<br><br>05/27/25 - 06/04/25 (9 days)<br><br>The May Shower Sheets documented R25 refused a shower on 05/12/25.<br><br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/09/25 at 08:00 AM, the hair on the back of his head was disheveled, and he was unshaven.<br><br>On 06/10/25 at 07:45 AM, R25 had his coat on and was unshaven.<br><br>On 06/11/25 at 10:30 AM, R25 had on his coat, and he was unshaven.<br><br>On 06/10/25 at 12:15 PM, Administrative Nurse F verified there was not a care plan with R25's ADLs and stated she would get it done right away.<br><br>On 06/11/25 at 10:15 AM, Administrative Nurse D stated that all residents should have an ADL care plan.<br><br>The facility's Comprehensive Care Plan policy, dated -3/25, documented that an individualized, comprehensive person-centered care plan was developed for each resident. The care plan would include measurable objectives and time frames that met the resident's medical, nursing, mental, cultural, and psychological needs. The care plan team was responsible for periodic review and updating the care plans. |

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| | 175202 | A. Building<br>B. Wing | 06/11/2025 |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents, with one reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to provide consistent bathing and grooming for one resident, Resident (R) 25. This placed the resident at risk for complications related to poor hygiene and impaired dignity.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R25 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness).<br><br>R25's Annual Minimum Data Set (MDS), dated [DATE], documented R25 had moderately impaired cognition. R25 required set-up assistance with oral hygiene, dressing, and personal hygiene. R25 was independent with mobility, transfers, and ambulation. R25 had no behaviors or rejection of care and felt it was very important to choose a bath, shower, or bed bath.<br><br>The ADL Care Area Assessment (CAA), dated 09/02/24, documented R25 had a risk for potential alterations in his ADL function related to his diagnoses. The CAA further documented staff would put interventions into place for his ADL status.<br><br>R25's Quarterly MDS, dated 03/21/25, documented R25 had severely impaired cognition. R25 required supervision with showers, and independent with dressing, oral hygiene, mobility, transfers, and ambulation. R25 had no behaviors or rejection of care.<br><br>R25's Care Plan, dated 03/12/25, lacked a care area with interventions for ADLs or rejection of care.<br><br>The April 2025 Shower Sheets documented R25 had not received a shower during the following days:<br><br>04/01/25 - 04/12/25 (12 days)<br><br>The April Shower Sheets documented R25 refused a shower on 04/09/25.<br><br>The May and June 2025 Shower Sheets documented R25 had not received a shower during the following days:<br><br>05/09/25 - 05/25/25 (17 days)<br><br>05/27/25 - 06/04/25 (9 days)<br><br>The May Shower Sheets documented R25 refused a shower on 05/12/25.<br><br>(continued on next page) |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/09/25 at 08:00 AM, the hair on the back of R25's head was disheveled, and he was unshaven.<br><br>On 06/10/25 at 07:45 AM, R25 had his coat on and was unshaven.<br><br>On 06/11/25 at 10:30 AM, R25 had his coat on and was unshaven.<br><br>On 06/10/25 at 12:54 PM, Licensed Nurse (LN) G stated he refused his shower a lot of the time. Staff were to inform the nurse when that happened, and other staff members reapproach him at a later time. LN G stated that after seven days without a shower, then she tried harder to get him to take a shower by calling the family.<br><br>On 06/11/25 at 10:15 AM, Administrative Nurse D stated staff reattempted, offered different alternatives than the shower, and should document in the EMR that the resident did not want a shower.<br><br>On 06/11/25 at 10:30 AM, Certified Nurse Aide (CNA) N stated he refused his shower, and that they would try to reapproach later. CNA N further stated his family requested that staff shave him even if he refused his showers.<br><br>On 06/11/25 at 10:45 AM, Certified Medication Aide (CMA) R stated he rarely took a shower, and staff just had to keep asking.<br><br>The facility's Quality of Life-Activities of Daily Living policy, dated 04/25, documented that the community environment and staff behaviors were directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being. Residents who are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. If a resident refuses care and treatment that may contribute to a decline, they are to inform and/or educate the resident of the benefits and risks of not accepting such interventions. Staff are to document such in the record, including the interventions identified in the care plan and in place to minimize the functional loss that was refused. The policy further documents staff are to document substitute interventions that were tried with consent or refused. |

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| | 175202 | A. Building<br>B. Wing | 06/11/2025 |

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| F 0729<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents, of which five were reviewed for sufficient and competent nurse staffing. Based on the record review and interview, the facility failed to verify one of the five Certified Nurse Aides (CNA) had a current license prior to employing her and allowing her to work the floor providing resident care.<br><br>Findings included:<br><br>- Review of the CNA Kansas Department for Aging and Disability Services (KDADS) nurse aide registry confirmation notice revealed CNA P's nurse aide license had expired on [DATE].<br><br>Review of the facility's date of hire information revealed CNA P was hired on [DATE].<br><br>On [DATE] at 02:37 PM, Consultant Staff GG verified CNA P license was inactive on [DATE], and the verification was conducted today. Consultant Staff GG stated Administrative Staff B was responsible for verifying CNAs' licenses were current before hiring them. Consultant Staff GG verified CNA P was scheduled to work the evening shift today, and she would not be working.<br><br>On [DATE] at 03:12 PM, Administrative Staff A verified the facility had hired CNA P on [DATE] with an expired license. Administrative Staff A stated the director of nursing (DON) and the business office manager were responsible for verifying nurse aids have a current license. Administrative Staff A verified CNA P had worked the floor providing care for residents for seven days with an expired license.<br><br>On [DATE] 03:52 PM, Administrative Nurse D stated from what she understood both the DON and the Administrative Staff B thought the other one had conducted the license verification check, prior to CNA P being hired and thought CNA P had a current active license.<br><br>The facility's Credentialing of Nursing Service Personnel Policy, revised 10/2024, documented nursing personnel requiring a license/certification would not be permitted to perform direct resident care services unless authorized by the Medical Director until all licensing/background checks had been completed. Nursing personnel who require a license or certification to perform resident care or treatment without direction or supervision must present verification of such license/certification to the DON before or upon employment. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold insulin (medication that lowers the level of glucose [a type of sugar] in the blood) when the medication was out of the physician's ordered parameters for one resident, Resident (R) 3. This placed the resident at risk for adverse effects related to medication.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R3 documented diagnoses of retention of urine (lack of ability to urinate and empty the bladder), diabetes mellitus (DM - when the body cannot use glucose, no enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), benign prostatic hyperpiesia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), and peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).<br><br>The Annual Minimum Data Set (MDS), dated [DATE], documented R3 had intact cognition. R3 was dependent upon the staff for showers, toileting, transfers, and dressing. R3 received insulin (a hormone that lowers the level of glucose in the blood), antidepressant (a class of medications used to treat mood disorders), and diuretic (medication used to promote the formation and excretion of urine) medications during the look-back period.<br><br>The Quarterly MDS, dated 05/28/25, documented R3 had severely impaired cognition. R3 was dependent upon staff for toileting hygiene, showers, dressing, personal hygiene, mobility, and transfers. R3 received insulin, antidepressant, and diuretic medication during the look-back period.<br><br>R3's Care Plan, dated 05/28/25, initiated on 03/02/20, directed staff to monitor blood glucose as ordered, administer diabetes medication as ordered by the doctor, and monitor for side effects and effectiveness. The update, dated 02/11/21, directed staff to obtain a fasting serum blood sugar (measures the level of glucose [sugar] in the blood after you've fasted [not eaten or drunk] for at least eight hours) as ordered by the physician. The update, dated 03/24/23, directed staff to monitor for compliance with diet and document any problems. The update, dated 03/27/23, directed staff to administer insulin as directed/ordered.<br><br>The Physician's Order, dated 06/28/24, directed staff to administer insulin glargine (long-acting insulin), 17 Units (U), twice a day, for DM. Hold if glucose < (less than) 120 mg (milligrams) per deciliter (dl).<br><br>R3's Medication Administration Record (MAR), dated April 2025, documented the following days R3 received his insulin when his blood sugar was out of the physician's ordered parameters:<br><br>04/06/25 at 06:00 PM - 102 mg/dl<br><br>04/14/25 at 09:00 AM - 112 mg/dl<br><br>(continued on next page) |

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|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 04/20/25 at 09:00 AM - 108 mg/dl<br><br>04/21/25 at 09:00 AM - 103 mg/dl<br><br>04/21/25 at 06:00 PM - 112 mg/dl<br><br>04/22/25 at 09:00 AM - 112 mg/dl<br><br>04/22/25 at 06:00 PM - 114 mg/dl<br><br>04/23/25 at 09:00 AM - 104 mg/dl<br><br>04/28/25 at 09:00 AM - 101 mg/dl<br><br>04/28/25 at 06:00 PM - 114 mg/dl<br><br>04/29/25 at 06:00 PM - 114 mg/dl<br><br>R3's MAR, dated May 2025, documented the following days R3 received his insulin when his blood sugar was out of the physician's ordered parameters:<br><br>05/14/25 at 09:00 AM - 96 mg/dl<br><br>05/24/25 at 09:00 AM - 82 mg/dl<br><br>05/25/25 at 09:00 AM - 100 mg/dl<br><br>On 06/10/25 at 09:00 AM, Licensed Nurse (LN) G, gowned and gloved, rubbed an alcohol swab over R3's left pointer finger, and obtained his blood sugar. LN G stated his blood sugar was out of parameters and would not be administering R3's insulin.<br><br>On 06/10/25 at 12:45 PM, LN G verified there were several days that R3 received his insulin when the out-of-physician ordered parameters.<br><br>On 06/10/25 at 02:53 PM, Administrative Nurse D stated, staff were to follow the physician's orders.<br><br>The facility's Obtaining a Fingerstick Glucose Level policy, dated 10/24, directed staff to verify that there was an order for the procedure. Staff were to document the results and follow facility policies and procedures for appropriate nursing interventions regards the blood sugar results. |