STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175215	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 67 residents. The sample included nine residents, with two residents reviewed for involuntary discharge. Based on record review and interviews, the facility failed to include the required information on an emergency discharge notice for Resident (R) 1 and on a 30-day discharge notice for R2. This deficient practice had the risk for miscommunication between the facility and resident/family, a possible missed opportunity for healthcare services, and involuntary discharge for R1 and R2.Findings included:- R1 admitted to the facility on [DATE] and discharged to the hospital on [DATE].R1's Electronic Medical Record (EMR) documented diagnoses of other Schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diffuse traumatic brain injury (TBI- an injury to the brain caused by external forces) with a loss of consciousness, affective mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), and encephalopathy (a broad term for any brain disease that alters brain function or structure).The admission Minimum Data Set (MDS) dated 10/29/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. R1 had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others one to three days in the assessment period. R1's overall goal was to remain in the facility with no active discharge planning.The Quarterly MDS dated 07/06/25, documented a BIMS was not conducted due to R1 being rarely/never understood. R1 had verbal behaviors directed towards others one to three days in the assessment period. R1 had no active discharge planning.The Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA) dated 11/12/24, documented R1 became agitated easily and became verbally threatening.The Psychosocial Well-Being CAA dated 11/13/24, documented R1 had verbal outbursts of yelling and cursing at staff and peers. R1's outbursts usually occurred when his requests did not happen immediately.R1's Care Plan dated 10/23/24, documented R1 planned to remain in the facility for permanent placement. The plan directed that staff addressed concerns in a timely manner and contacted R1's responsible party for any concerns.R1's Care Plan dated 01/06/25 and revised 04/04/25, documented R1 had the ability and history of being physically aggressive with others related to anger, poor impulse control, and TBI. The plan directed staff to assess and anticipate R1's needs; the facility monitored, documented, and reported any signs of R1 posing a danger to himself and others; and R1 lived in a private room due to aggression.R1's EMR revealed the following:An Orders- Administration Note on 07/11/25 at 09:15 AM documented R1 had a non-injury fall in his room by the closet door while attempting to look inside his closet. R1 denied hitting his head and denied any injuries anywhere on his body. The staff notified the Assistant Director of Nursing (ADON), R1's family, and the provider.An Orders- Administration Note on 07/11/25 at 11:54 AM documented the facility received an order to send R1 to the emergency room (ER) to evaluate and treat for R1's complaints of not feeling well. R1 left in a wheelchair via facility transportation. R1's family was aware.A Nurses Note on 07/11/25 at 02:49 PM documented the nurse communicated clinical information to Consultant GG. Administrative Staff A communicated to Consultant GG that R1 was not able to return to the facility due to behavior indicating a potential risk to himself and others. Administrative Staff A informed Consultant GG of the situation as they were unable to adequately meet R1's needs at that time.A Social Services Note on 07/14/25 at 01:02 PM documented R1 was sent to the hospital per his request and his representative consented. Due to R1's aggression, the facility determined they could not meet R1's needs. R1 had numerous altercations with other residents resulting in police reports made to police. Administrative Staff A notified the hospital that the facility would not accept R1 back due to the above reasons.Upon request, the facility provided a Notice of Discharge dated 07/11/25 for R1. The notice documented the facility had notified R1 of the necessity to discharge immediately on 07/11/25. The notice documented the reasons for the discharge as R1's needs could not be met by the facility and the safety of other individuals was endangered. The notice listed R1's representative's address as his discharge address. The notice explained R1's right to an appeal but did not explain how to file an appeal, who would help R1 file an appeal, or the correct agency and contact information to file an appeal with. The notice listed the long-term care ombudsman's (LTCO) address and phone number but did not list the LTCO's email address. Administrative Staff A signed the notice on 07/14/25.On 08/05/25 at 12:13 PM, Administrative Staff A stated

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 67 residents. The sample included nine residents, with three residents reviewed for discharge. Based on record review and interviews, the facility failed to document a recapitulation of stay for Residents (R) 2, R3, and R4. This deficient practice had the risk for miscommunication of services received during the stay in the facility and if post-discharge care needs for the affected residents.Findings included:- R2 admitted to the facility on [DATE] and discharged on 07/31/25.R2's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (major mood disorder), repeated falls, and generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).The admission Minimum Data Set (MDS) dated 03/04/25, documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R2's overall goal was to remain in the facility, and she had no discharge plan.The Quarterly MDS dated 05/30/25, documented R2 had a BIMS score of 15, which indicated intact cognition. R2 had active discharge planning with a discharge date three or fewer months away.The Functional Abilities Care Area Assessment (CAA) dated 03/13/25, documented R2 needed assistance with functional abilities, and she reported weakness from a recent illness.R2's Care Plan, dated 07/17/25, documented R2 wished to be discharged back to the community to her own home. The plan directed the facility established a pre-discharge plan with R2 and evaluated her progress and revised the plan as needed. The plan directed staff evaluated and discussed with R2 her prognosis for independent or assisted living. The plan directed staff evaluated R2's motivation to return to the community and make arrangements with required community resources to support independence post-discharge.R2's EMR revealed the following:A Social Services Note on 07/16/25 at 12:54 PM, documented a Zoom meeting was held with R2 and her insurance care team for her return back into the community. R2's insurance care team was aware that R2 received a 30-day notice due to non-payment and the discharge date was 07/31/25. During the meeting, R2 had to be redirected at times due to accusations being made. R2 stated she was looking into a place in another town. R2's insurance care team asked if her 30-day notice could be extended, and was informed that corporate would make that decision. R2 stated she did not have to leave if she did not want to. The insurance care team discussed possibly getting funds for a motel until an apartment was available.A Social Services Note on 07/18/25 at 02:02 PM, documented a meeting was held regarding R2's upcoming discharge. It was discussed that R2 was capable of managing medications and was independent with her activities of daily living (ADL). The insurance care team mentioned they had roadblocks with finding placement due to R2's background and they continued to explore housing for her. R2 was resistant to receiving facility assistance and would not divulge any personal finances.A Nurses Note on 07/31/25 at 10:28 AM, documented the nurse received discharge orders to discharge home with current medications and no narcotics (pain medication).A Nurses Note on 07/31/25 at 12:46 PM, documented the staff notified Consultant GG of R2 requesting medication to be sent to the pharmacy after she self-discharged on 07/31/25. Consultant GG stated R2 could receive a seven-day supply before discharge but R2 already discharged . Consultant GG stated he could not call those medications in and R2 would have to contact an outside primary care provider to get narcotics called in.A Social Service Note on 07/31/25 at 12:51 PM, documented R2 chose to discharge to a motel in another town. Her insurance care team was unaware of her intentions. The facility transported her to the motel.R2's EMR lacked documentation of a discharge summary including a recapitulation of stay.On 08/06/25 at 10:59 AM, Social Services X stated when a resident planned to discharge, she talked to the resident and/or their representative about setting up home health and obtaining pharmacy orders.On 08/06/25 at 11:50 AM, Licensed Nurse (LN) G stated when a resident discharged , she completed a head-to-toe assessment, completed a medication reconciliation with the resident and/or their representative, asked the resident for their designated pharmacy, and made sure the resident had a 30-day supply of medications sent to the facility or if authorized by the provider, sent the medications with the resident or their representative. She stated she documented in the discharge instructions assessment which included vital signs, any skin issues, treatments provided while they were a resident and why they were in the facility, medications and when to take them. LN G was unable to find the recapitulation of stay in the discharge instructions assessment when asked. She confirmed the assessment used for discharge instructions was titled [NAME]-Discharge Instructions- Interdiscipline. LN G stated she had not been instructed on if the facility had a separate discharge summary separate than the discharge

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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	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 67 residents. The sample included nine residents, with three residents reviewed for bathing. Based on observations, record review, and interviews, the facility failed to provide consistent bathing for Residents (R) 5 and R6. This deficient practice had the risk of poor hygiene and decreased self-esteem and dignity for the affected residents.Findings included:- R5's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness and unsteadiness on feet.The admission Minimum Data Set (MDS) dated 03/14/25 documented R5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R5 required substantial/maximal assistance with bathing. The Quarterly MDS dated 06/04/25, documented R5 had a BIMS score of 13, which indicated intact cognition. R5 required partial/moderate assistance with bathing.The Functional Abilities Care Area Assessment (CAA) dated 03/21/25 documented R5 reported weakness to upper and lower extremities as well as decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).R5's Care Plan dated 03/14/25 documented R5 preferred female caregivers only for showers, toileting, and all cares provided due to modesty and comfort level. The plan directed staff promoted R5's preference of choice regarding her individualized care.R5's Care Plan dated 05/22/25, documented R5 had an activities of daily living (ADL) self-care performance deficit requiring minimal to extensive assistance with ADLs. The plan directed R5 required extensive assistance with bathing.The Documentation Survey Report for 05/01/25 to 08/05/25 revealed the following documentation for R5's ADL- Bathing on Tuesday and Friday task: not applicable (NA) for 19 out of 28 scheduled bathing days, resident unavailable on one out of 28 scheduled bathing days, and blank documentation for eight out of 28 scheduled bathing days.The Documentation Survey Report for 05/01/25 to 07/29/25 revealed R5 received shampoo with her shower/bath on 05/23/25, 06/03/25, and 06/17/25.On 08/05/25 at 03:57 PM, R5 sat on the side of her bed. Her hair appeared slightly greasy, and she had debris noted on her gown. R5 stated she last received a shower last week and she was not getting her showers regularly. She stated she would like more showers and would be happy with one shower a week. R5 stated not getting regular showers made her feel dirty.On 08/06/26 at 11:40 AM, Certified Nurse Aide (CNA) M stated CNAs were responsible for bathing and they had assigned bathing. She stated the CNAs struggled to get bathing done recently. CNA M stated she documented bathing on paper and in the EMR. She stated if NA was documented, it might have meant that the CNA did not get to the bathing that day or they did not know how to document the bathing. She stated if a resident refused bathing, she asked them twice and if they continued to refuse then another CNA went in to ask them before they reported it to the nurse. CNA M stated R5 preferred to bathe in the sink, and it depended on how she felt that day if she accepted bathing.On 08/06/25 at 11:50 AM, Licensed Nurse (LN) G stated CNAs were responsible for their assigned bathing and when completed, the CNA gave the nurse the shower sheet and documented in the EMR. She stated if a resident refused bathing, the CNA told the nurse and filled out the shower sheet as a refusal then the nurse attempted to get the resident to bathe. LN G stated the CNAs documented refusals in the EMR and if the documentation was blank then she thought that meant the bathing did not get done. She stated R5 voiced her concerns but R5 did not report any bathing concerns to her.On 08/06/25 at 12:06 PM, Administrative Nurse D stated CNAs completed bathing and documented in the EMR and on a shower sheet. She stated if a resident refused bathing, the CNA reapproached one more time than the nurse offered bathing. Administrative Nurse D stated NA meant not applicable and she expected no blank documentation. She stated she expected CNAs to chart showers and refusals in the EMR. Administrative Nurse D stated she expected CNAs to complete their assigned bathing. She stated she had only had one resident complain about not getting baths and that was R5.The facility's Resident Showers policy, not dated, directed the facility assisted residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice. The policy directed residents were provided showers as per request or as per facility schedule protocols and based upon resident safety.- R6's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness, unsteadiness on feet, and need for assistance with personal care.The admission Minimum Data Set (MDS) dated 04/14/25, documented R6 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R6 required substantial/maximal assistance with bathing.The Quarterly MDS dated 07/08/25, documented R6 had a BIMS score of 14, which indicated intact cognition. R6 required substantial/maximal assistance with bathing The Functional Abilities Care Area Assessment (CAA) dated