STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175216	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wathena Healthcare & Rehabilitation Center	2112 Highway 36 Wathena, KS 66090

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** 42966 The facility identified a census of 39 residents. The sample included 12 residents with three residents reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide a bed hold policy notice to Resident (R) 4 and R20 or their representatives when they transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R4 and R20. Findings included: - R4 admitted to the facility on [DATE], discharged to the hospital on 03/31/24, readmitted to the facility on [DATE], discharged to the hospital on 05/20/24, and readmitted to the facility on [DATE]. R4's Electronic Medical Record (EMR) documented diagnoses of nausea, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and cough. The Annual Minimum Data Set (MDS) dated [DATE], documented that R4 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The Quarterly MDS dated [DATE], documented R4 had a BIMS score of 15 which indicated intact cognition. The Functional Abilities Care Area Assessment (CAA) dated 01/25/24, documented that staff assisted R4 with activities of daily living (ADL) care as needed and anticipated her care. R4's Care Plan dated 07/15/22, documented R4 had an ADL self-care performance deficit and required assistance with her care needs. Staff encouraged R4 to participate to the fullest extent possible with each interaction. R4's EMR revealed a General Note on 05/20/24 at 05:17 PM that R4 had nausea and vomiting after lunch and experienced pain in her abdomen. The facility sent R4 to the emergency room (ER) and notified R4's representative. (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: 175216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon request, the facility did not provide documentation that R4 or her representative received a written notice of the bed hold policy for R4's transfer to the hospital on 03/31/24 and 05/20/24. On 09/23/24 at 02:16 PM, R4 lay in bed and watched television. On 09/25/24 at 01:26 PM, Social Services X stated when a resident transferred to the hospital, she sent a written notification of transfer to their representative. She stated the nurse filled out a bed hold in the EMR but did not send the notice out to the representative. On 09/25/24 at 01:31 PM, Licensed Nurse (LN) G stated when a resident transferred to the hospital, the nurse completed a transfer form in the EMR and then notified the family and doctor. He stated the nurse filled out a bed hold assessment that documented if the resident was their own person but he did not give out the bed hold to the resident or their representative. On 09/25/24 at 01:47 PM, Administrative Nurse D stated when a resident transferred to the hospital, the nurse notified the on-call nurse and the resident's representative. She stated the nurse completed a bed hold assessment in the EMR, but she was unsure if the staff sent out the bed hold policy to the representative. The facility's Bed Hold Notice Upon Transfer policy, dated 2023, directed at the time of transfer for hospitalization or therapeutic leave, the facility provided the resident and/or their representative a written notice which specified the duration of the bed-hold policy and addressed information explaining the return of the resident to the next available bed. The facility failed to provide a bed hold policy notice to R4 or their representatives when she transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R4. 41713 - R20's Electronic Medical Record (EMR) documented diagnoses of chronic respiratory failure a long-term condition where there is not enough oxygen), hypertension (HTN-elevated blood pressure), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and a pressure ulcer (localized injury to the skin and underlying tissue usually over a bony) of sacral (large triangular bone/area between the two hip bones) area. R20's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R20 had impairment of both lower extremities. R20 was dependent on staff for all functional abilities. R20 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). R20 had an unhealed Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) pressure ulcer. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R20 had impairment of both lower extremities. R20 was dependent on staff for all functional abilities. R20 had an indwelling catheter. R20 had an unhealed stage 4 pressure ulcer. R20 04/25/24's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R20's Pressure Ulcer Care Area Assessment (CAA) dated 10/18/23 documented that staff was to assist with repositioning per the protocol and as needed to help maintain skin integrity. The licensed nursing staff was to monitor skin integrity every week to help monitor for any skin issues. Incontinence creams were to be used as needed to help maintain skin integrity. A pressure redistributing surface was in place on the resident's bed and on his wheelchair to help maintain skin integrity. R20's Care Plan last revised on 07/22/24 directed staff to monitor and document any signs or symptoms of infection in any open area. The facility was unable to provide evidence the bed hold policy was provided to R20 on 12/10/23, 02/23/24, 03/07/24, 04/05/24, 04/25/24, 05/18/24, 06/26/24, and 07/31/24. On 09/25/24 at 01:26 PM, Social Services X stated when a resident transferred to the hospital, she sent a written notification of transfer to their representative. Social Services X stated the nurse filled out a bed hold in the EMR but did not send the notice out to the representative. On 09/25/24 at 01:31 PM, Licensed Nurse (LN) G stated when a resident was transferred to the hospital, the nurse completed a transfer form in the EMR, then they would notify the family and doctor. He stated the nurse filled out a bed hold assessment that documented if the resident was their own person, but he did not give out the bed hold to the resident or their representative. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/24 at 01:47 PM, Administrative Nurse D stated when a resident transferred to the hospital, the nurse notified the on-call nurse and the resident's representative. She stated the nurse completed a bed hold assessment in the EMR, but she was unsure if the staff sent out the bed hold policy to the representative. The facility's Bed Hold Notice Upon Transfer policy, not dated, directed at the time of transfer for hospitalization or therapeutic leave, the facility provided the resident and/or their representative a written notice that specified the duration of the bed-hold policy and addressed information explaining the return of the resident to the next available bed. The facility failed to provide a bed hold notice to R20 or their representative when R20 transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility or the same room for R20.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42966 The facility identified a census of 39 residents. The facility had one main kitchen and one dining area. Based on record review and interview, the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed the residents at risk for unmet dietary and nutritional needs. Findings included: - On 09/23/24 at 04:27 PM, Dietary BB stated the registered dietitian visited every two weeks. Dietary BB stated she still needed to pass the test to become a CDM because she took it once and did not pass but had to wait 90 days to try again. On 09/24/24 at 11:05 AM, Dietary BB stated she had been the dietary manager for four years and it had taken a couple of years to get the CDM education completed because of the pandemic. On 09/25/24 at 01:36 PM, Administrative Staff A stated Dietary BB had taken the state test to become a CDM but did not pass. He stated the current plan included her taking the test again but they might have to see if another dietary member wanted to become certified or find a CDM if it did not work out. The facility policy Organizational Plan and Roles of Key Staff documented that in states without an established minimum standard, the following qualifications of the Dining Services Manager should be considered: Certified Dietary Manager {CDM, CFPP) credential; or Certified food service manager; or National certification for food service management and safety from a national certifying body; or Associate's or higher degree in food service management or hospitality from an accredited institution of higher learning. The facility failed to ensure the director of food and nutrition services had the required qualifications of a CDM. This placed the residents at risk for unmet dietary and nutritional needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42966 The facility identified a census of 39 residents. The facility had one main kitchen. Based on observations, record review, and interviews, the facility failed to ensure the big cooler maintained an appropriate temperature range, failed to ensure staff consistently monitored cooler and freezer temperatures, and failed to ensure staff consistently monitored the dishwasher temperatures and chemical sanitation levels. The facility further failed to ensure adequate hand hygiene during meal service. This deficient practice placed residents at risk for food-borne illnesses. Findings included: - On the initial tour of the kitchen on 09/23/24 at 08:11 AM, the big cooler had a temperature of 46 degrees Fahrenheit. The big cooler contained produce, cheese, condiment containers, eggs, sour cream, cottage cheese, and other food items. On 09/24/24 at 07:48 AM, Administrative Nurse D delivered a bowl to a resident in the dining room and then helped a male resident with a clothing protector. She then asked Resident (R) 3 if he wanted a clothing protector and helped him put it on. The kitchen staff brought out a cart of food and without performing hand hygiene, Administrative Nurse D grabbed a plate, sat it back down, and then touched another plate on another cart. She then grabbed an empty tray and moved the breakfast plate/bowl/cups to the tray. Administrative Nurse D moved another covered plate on the cart and then pushed the cart towards the kitchen door. R4's clothing protector fell off and she attempted to refasten it then walked over to the stack of clean clothing protectors to grab a different one for R4. Administrative Nurse D placed the previous clothing protector on the table after placing the new clothing protector on R4. She then walked away from the table moved her hair out of her face then pushed a food cart towards a female resident. She gave the female resident cups of fluids, and her breakfast tray then pushed the cart towards the kitchen. Administrative Nurse D then performed hand hygiene. On 09/24/24 at 11:19 AM, the big cooler had a temperature of 46 degrees Fahrenheit. Dietary BB verified the big cooler's temperature and reported the temperature at 48 degrees Fahrenheit. Review of the Temp Log- Big Cooler from 09/01/24 to 09/22/24 revealed missing temperature monitoring documentation on 09/01/24 evening (PM), 09/06/24 morning (AM) and PM, 09/08/24 PM, 09/09/24 PM, 09/11/24 PM, 09/14/24 PM, 09/15/24 PM, 09/18/24 PM, 09/20/24 PM, and 09/21/24 PM. The Temp Log instructions directed staff recorded temperatures for each cooler in the department; record time, temperature, and initials twice per day (AM and PM); and notify the supervisor immediately if the cooler temperature was not within the acceptable range of 41 degrees Fahrenheit to 33 degrees Fahrenheit. Review of the Temp Log- Milk and Juice Cooler from 09/01/24 to 09/22/24 revealed missing temperature monitoring documentation on 09/01/24 PM, 09/06/24 AM and PM, 09/08/24 PM, 09/09/24 PM, 09/11/24 PM, 09/14/24 PM, 09/15/24 PM, 09/18/24 PM, 09/20/24 PM, and 09/21/24 PM. The Temp Log instructions directed staff recorded temperatures for each cooler in the department; record time, temperature, and initials twice per day (AM and PM); and notify the supervisor immediately if the cooler temperature was not within the acceptable range of 41 degrees Fahrenheit to 33 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Temp Log- Kitchen Big Freezer from 09/01/24 to 09/22/24 revealed missing temperature monitoring documentation on 09/01/24 PM, 09/06/24 AM and PM, 09/08/24 PM, 09/09/24 PM, 09/11/24 PM, 09/14/24 PM, 09/15/24 PM, 09/18/24 PM, 09/20/24 PM, and 09/21/24 PM. The Temp Log instructions directed staff recorded temperatures for each cooler in the department; record time, temperature, and initials twice per day (AM and PM); and notify the supervisor immediately if the freezer temperature was not within the acceptable range of two degrees Fahrenheit or below. Review of the Temp Log- Kitchen Small Freezer from 09/01/24 to 09/22/24 revealed missing temperature monitoring documentation on 09/01/24 PM, 09/06/24 AM and PM, 09/08/24 PM, 09/09/24 PM, 09/11/24 PM, 09/14/24 PM, 09/15/24 PM, 09/18/24 PM, 09/20/24 PM, and 09/21/24 PM. The Temp Log instructions directed staff recorded temperatures for each cooler in the department; record time, temperature, and initials twice per day (AM and PM); and notify the supervisor immediately if the freezer temperature was not within the acceptable range of two degrees Fahrenheit or below. A review of the Dish Machine Log- Low Temp from 09/01/24 to 09/22/24 revealed missing temperature and sanitizer level monitoring documentation for 16 out of 66 possible scheduled times. The Dish Machine Log instructions directed staff to record wash temperature, sanitizer parts per million (ppm), and initials three times per day; and notify the supervisor immediately if sanitizer ppm was not within the acceptable range of 50 to 100 ppm. A review of the Pots and Pans Sanitization Log from 09/01/24 to 09/22/24 revealed missing sanitizer level monitoring documentation for 12 out of 66 possible scheduled times. The Pots and Pans Sanitization Log did not include instructions. On 09/24/24 at 11:12 AM, Dietary CC stated she checked refrigerator and freezer temperatures every morning. She stated the cook's responsibility included checking the refrigerator and freezer temperatures in both morning and evening and the dietary aide checked the dishwasher temperature and sanitizer levels. Dietary CC stated the refrigerator temperature had to stay below 41 degrees Fahrenheit and if the temperature reached above 41 degrees Fahrenheit, she let Dietary BB know about it. On 09/24/24 at 11:13 AM, Dietary BB stated the cook's responsibility included checking refrigerator and freezer temperatures and the dietary aide monitored the dishwasher temperature and sanitizer levels. She stated she reviewed the monitoring logs every morning and if they were not completed, she called the staff to do them. Dietary BB stated if staff discovered refrigerator or freezer temperatures out of range, they notified her and she notified maintenance. On 09/25/24 at 01:28 PM, Certified Medication Aide (CMA) R stated staff performed hand hygiene after each tray during meal pass. On 09/25/24 at 01:31 PM, Licensed Nurse (LN) G stated staff performed hand hygiene between trays during meal service. On 09/25/24 at 01:47 PM, Administrative Nurse D stated if staff passed trays without touching anything in the resident's room, they performed hand hygiene every three to four residents. She stated if staff passed trays in the dining room, they performed hand hygiene in between residents because they usually touched the residents to set them up for the meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Food Storage policy, dated 2020, directed the facility to set refrigerators to the proper temperature and the setting must ensure the internal temperature of food was 41 degrees Fahrenheit or lower and staff conducted random temperature checks of food items. The facility's Dishwashing: Machine Operation policy, dated 2020, directed twice daily, staff recorded either the final rinse temperature for high-temperature dishwashing machines or sanitizer concentration for low-temperature dishwashing machines with chemical sanitizer. The facility's Hand Hygiene policy, dated 2024, directed all staff to perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The facility failed to ensure the big cooler maintained an appropriate temperature range, failed to ensure staff consistently monitored cooler and freezer temperatures, and failed to ensure staff consistently monitored the dishwasher temperatures and chemical sanitation levels. The facility further failed to ensure adequate hand hygiene during meal service. This deficient practice placed residents at risk for food-borne illnesses.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 39 residents. The sample included 12 residents. Based on interviews and record review, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 39 residents residing in the facility. Findings Included: - An inspection of the Facility assessment dated [DATE] provided by the facility revealed the following: The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked the staffing levels required for each shift. The assessment lacked an informed contingency plan for events that do not require activation of the facility's emergency plan but have the potential to impact resident care. The assessment lacked a contingency plan to maximize recruitment and retention of direct care staff. The assessment failed to identify the means of input gathered from the residents and their representatives when formulating the assessment data. On 09/25/24 at 01:54 PM Administrative Staff A stated the facility had just revised the facility assessment on 08/01/24 and thought all areas had been covered for the new requirements. Administrative Staff A stated he would be going over the new requirements again and adding in the areas that were lacking. The facility was unable to provide a policy related to its facility assessment as requested on 09/25/24. The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 39 residents residing in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42966 The facility identified a census of 39 residents. Based on observations, record review, and interviews, the facility failed to ensure staff followed Enhanced barrier precautions (EBP), and failed to ensure staff performed appropriate hand hygiene during medication pass. The facility further failed to assess, identify risks, and create a plan to address the risk for Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations) or other opportunistic waterborne pathogens. This deficient practice placed the residents at risk for infectious diseases. Findings included: - On 09/24/24 at 08:58 AM, Resident (R)8 had an isolation basket with isolation supplies on the back of her room door without a sign denoting the type of isolation or PPE required. Licensed Nurse (LN) G performed wound care on R8 without wearing an isolation gown. On 09/24/24 at 09:20 AM, R16 had an isolation basket with isolation supplies on the back of his room door without a sign denoting the type of isolation or PPE required. Certified Nurse Aide (CNA) P performed catheter care without wearing an isolation gown. On 09/25/24 at 08:03 AM, Certified Medication Aide (CMA) R obtained R26's blood pressure in his room. She exited his room then donned (put on) gloves and disinfected the blood pressure machine and cuff with disinfecting wipes. CMA R doffed (removed) gloves but did not perform hand hygiene before preparing R26's medications. On 09/25/24 at 08:22 AM, CMA R prepared R29's medications. She donned gloves and placed a tablet of Seroquel (antipsychotic medication- a class of medications used to treat major mental conditions that cause a break from reality) in a pill cutter, placed half a tablet in a medication cup, then wasted the other half in the sharps container. CMA R disinfected the tablet cutter with a disinfectant wipe and then doffed gloves. She did not perform hand hygiene before continuing with R29's medication pass. Upon request, the facility was unable to provide a Legionella water management plan. On 09/25/24 at 12:05 PM, Maintenance U stated he had not done anything with the Legionella water management plan yet but it would be his responsibility. On 09/25/24 at 01:28 PM, CMA R stated staff performed hand hygiene after touching residents and before leaving the resident's room. She stated she performed hand hygiene after taking off her gloves. CMA R stated staff knew what residents required EBP from the signs on the doors and sometimes from the report. On 09/25/24 at 01:31 PM, LN G stated staff performed hand hygiene before and after care, after touching residents, and before and after using gloves. He stated staff knew what residents required EBP by their name being in blue outside their door. LN G stated the facility held an in-service about EBP and they no longer had isolation signs. He stated staff wore gloves and isolation gowns with any direct care with residents on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/25/24 at 01:36 PM, Administrative Staff A stated in December 2023, the facility completed the Legionella assessment and planned to get the testing in place but the maintenance man at the time passed away and it was not put into place. On 09/25/24 at 01:47 PM, Administrative Nurse D stated staff performed hand hygiene any time they went into a resident's room and when coming out of their room, before and after putting gloves on, and when going from a dirty to clean procedure with glove changes. She stated staff knew what residents required EBP by their name being in blue outside their room. Administrative Nurse D stated residents on EBP had isolation baskets hanging on the back of their door that had gloves and isolation gowns to be worn. She stated staff discussed EBP at length. Administrative Nurse D stated the facility did have isolation signs on the door but they were told to take them down and find a new way to mark what residents required EBP. She stated she expected staff to wear isolation gowns and gloves any time they performed direct contact with residents on EBP. The facility's Legionella Surveillance policy, last revised 05/31/22, directed the facility to establish primary and secondary strategies for the prevention and control of Legionella infections. The facility's Enhanced Barrier Precautions policy, dated 04/01/24, directed EBP referred to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employed targeted gown and glove use during high-contact resident care activities. The policy directed the facility to have discretion on how to communicate to staff which residents required the use of EBP, as long as staff were aware of which residents required the use of EBP before providing high-contact care activities. The facility's Hand Hygiene policy, dated 2024, directed all staff to perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy directed if a task required gloves, staff performed hand hygiene before donning gloves and immediately after removing gloves. The facility failed to ensure staff followed EBP, and failed to ensure staff performed appropriate hand hygiene during medication pass. The facility further failed to assess, identify risks, and create a plan to address the risk for Legionella disease or other opportunistic waterborne pathogens. This deficient practice placed the residents at risk for infectious diseases.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER: Wathena Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2112 Highway 36, Wathena, KS 66090	

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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 41713 The facility identified a census of 39 residents. Based on record review and interviews, the facility failed to ensure agency direct care staff had received the required infection control training. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 07/10/24 at 10:40 AM a review of the training for agency Certified Nurses Aid (CNA) M, and CNA N and CNA O revealed the following: CNA M's facility-provided credentialling file lacked evidence training was completed for infection control training. CNA N's facility-provided credentialling file lacked evidence training was completed for infection control training. CNA O's facility-provided credentialling file lacked evidence training was completed for infection control training. On 09/25/24 at 01:48 PM Administrative Nurse D stated the facility did go over resident rights and Abuse, Neglect, and Exploitation training with the agency staff. Administrative Nurse D stated she would begin doing the communication, infection control, and the other required nurse aide training upon hire and orientation. On 09/25/24 at 01:5 PM Administrative Staff A stated that he just assumed that agency staff had completed the required training, but none of that information was sent by the Agency company. Administrative Staff A stated that staff would ensure that the training was completed upon their first shift of working from this time forward. The facility did not provide a policy regarding required training for nurse aide staff as requested. The facility failed to ensure agency direct care staff had received infection control training. This placed the residents at risk for impaired care and decreased quality of life.