STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175249	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care Center	1630 W 2nd Street Chanute, KS 66720

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 59 residents. The sample included 17 residents, including six residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure informed consent including purpose, risks versus benefits, and expected therapeutic benefits for the use of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), anxiolytic (medication used to treat symptoms of anxiety) and other psychotropic medications (drugs that affect the brain and nervous system to treat mental illnesses) for Resident (R) 6. This placed the resident at risk for uninformed treatment decisions.Findings included:- R6's Electronic Medical Record (EMR) documented the following diagnoses: panic disorder (an anxiety disorder) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).R6's EMR documented the following physician's orders:Duloxetine (an antidepressant medication), 120 milligrams (mg), by mouth, every morning, for a diagnosis of depression, ordered 07/29/25. Risperidone (an antipsychotic medication), 1 mg, per percutaneous endoscopic gastrostomy (PEG- tube placed in the wall of the stomach), twice daily, for a diagnosis of resistant depression, ordered 10/28/24. Trazodone (an antidepressant medication), 100 mg, every day, for a diagnosis of insomnia (inability to sleep), ordered 05/07/25. R6's EMR lacked documentation of informed consent for R6's psychotropic and antipsychotic medications.On 08/06/25 at 07:33 AM, Administrative Nurse D stated it was the expectation for staff to obtain psychotropic drug consents before the medication was initiated. The facility policy for Use of Psychotropic Medications, undated, included: Prior to initiating or increasing a psychotropic medication, the resident, family, and/o /or resident representative must be informed of the benefits, risks, and alternatives for the medication.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 59 residents. The sample included 17 residents, including one resident reviewed for discharge. Based on interview and record review, the facility failed to provide the Ombudsman (a resident advocate) with a notice of transfer for Resident (R)67 and R69. This placed the residents at risk of impaired residents rights related to discharge. Findings included: -R69's admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. She was admitted to the facility on [DATE] with a goal to discharge to the community.The Return to Community Referral Care Area Assessment (CAA), dated 04/22/25, did not trigger. R69's Discharge MDS, dated 06/03/25, documented the resident had a planned discharge to the community. R69's Care Plan for discharge planning instructed staff to identify any resources the resident may need upon dismissal to home.R69's EMR revealed a Progress Note dated, which documented that the resident had been discharged from the facility, accompanied by family.R69's EMR lacked documentation that the Ombudsman was notified of the resident's discharge from the facility. The facility was unable to provide evidence; upon request, the Ombudsman was notified of the R69's discharge.On 08/06/25 at 12:14 PM, Social Services X stated the Ombudsman had not been notified of R69's discharge as required.The facility policy for Transfer Notification Policy, 09/2018, included: It is the policy of the facility to notify the resident, representative and the state ombudsman of an emergency transfer, such as transfers to an acute care facility.- R67's Electronic Medical Record (EMR) revealed a diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).R67's admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating moderately impaired cognition. He entered the facility on 06/02/25 with his overall goal being to discharge to the community.The Discharge to Community Care Area Assessment (CAA), dated 06/06/25, did not trigger.R67's Discharge Return Anticipated MDS, dated 07/11/25, documented that he had been discharged to a critical access hospital.R67's Care Plan plan for CHF instructed staff to monitor the resident for shortness of breath (SOB).Review of R67's EMR revealed the resident had been discharged to the hospital on [DATE].R67's EMR lacked documentation of the Ombudsman (a resident advocate) being notified of the resident's discharge from the facility. The facility was unable to provide evidence; upon request, the Ombudsman was notified of the R69's discharge. On 08/06/25 at 12:14 PM, Social Services staff X stated the ombudsman had not been notified of the resident's discharge as required. The facility policy for Emergency Transfer Notification Policy, 09/2018, included: It is the policy of the facility to notify the resident, representative, and the state ombudsman of an emergency transfer, such as transfers to an acute care facility.

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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 reported a census of 59 residents. The sample included 17 residents, including four residents who were reviewed for activities of daily living (ADL). Based on observation, interview, and record review, the facility failed to provide the necessary ADL care for one sampled resident, Resident (R)8, who did not get showered. This deficient practice placed the affected resident at risk for impaired quality of life and poor hygiene.Findings included:- Review of the Electronic Health Record (EHR) revealed that R8's diagnoses included cutaneous abscess of right axilla (cavity containing pus and surrounded by inflamed tissue), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), end stage renal disease (ESRD- the kidneys are no longer able to adequately support the body's needs), periprosthetic fracture around internal prosthetic right knee joint (a break in the bone surrounding the knee replacement implant), pressure ulcer of sacral region Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R8's admission Minimum Data Set (MDS), dated 06/20/25, documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognitive impairment. He required a wheelchair and walker for mobility; he required set-up/clean-up assistance for eating, partial to moderate assistance for oral and personal hygiene, and was dependent on staff for bathing and all other ADLs.The Functional Abilities Care Area Assessment (CAA), dated 06/20/25, documented R8 required assistance in oral hygiene and was ADL dependent on staff for toileting hygiene and bathing.The Urinary Incontinence and Indwelling Catheter CAA, dated 06/20/25, noted that R8 was dependent on staff for toileting hygiene and was frequently incontinent. The Pressure Ulcer/Injury CAA, dated 06/20/25, triggered that R8 was at risk for developing pressure ulcers, and had one or more unhealed pressure ulcer(s) at Stage 2 or higher; he required ADL assistance for movement in bed. R8's Care Plan for ADLs, dated 06/29/25, instructed staff to provide partial/moderate assistance with bed mobility, oral and personal hygiene, supervision with set-up assistance for eating, and he was dependent on staff for toileting hygiene and wheelchair mobility. R8's EHR, under the bathing Tasks, lacked evidence that R8 received bathing in July 2025. There were no documented bathing refusals in July 2025.A review of the July Shower Sheets revealed R8 received one shower on 07/17/25, and no bathing refusals were recorded.Observation on 08/04/25 at 11:45 AM, staff transferred R8 from his bed to a wheelchair using a full-body mechanical lift.Observation on 08/05/25 at 01:48 AM, Certified Medication Aide (CMA) R prepared R8 for bathing and placed the lift sheet under him for transfer.Observation on 08/05/25 at 02:55 PM, R8 propelled himself about the hallway via a wheelchair. R8 reported that he received a shower. On 08/04/25 at 08:42 AM, R8 reported that he had only been allowed one shower since admission and was told by staff he would get a shower two weeks ago, but never did. He stated that he had requested showers but did not get them and had to give himself bed baths.On 08/05/25 at 12:54 PM, CMA R stated that bathing was attempted three times weekly for residents, though some residents prefer bathing twice a week. CMA R further stated that if a resident refused bathing, staff documented R, for refused, on the shower sheet, and then it was circled and signed by the resident. On 08/05/25 at 01:21 PM, Licensed Nurse (LN) G reported that residents were offered bathing at least twice a week; some preferred to bathe once a week. LN G also stated that if a resident refused, then the aide was supposed to notify the nurse to assess the reason for refusal. If the resident continued to refuse, then the refusal was recorded on the shower sheet and initialed or signed by the resident.On 08/05/25 at 01:30 PM, Administrative Nurse D stated that bathing was based on the resident's preference; if the resident refused, then it was recorded as refused on the shower sheet and in the EHR. Administrative Nurse D further stated that it was expected that the staff recorded the bathing or the bathing refusals.The facility policy Resident Showers, dated 2024, documented that it was the practice of the facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues. It listed that residents would be provided showers as per resident request or facility schedule, and based upon resident safety.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 59 residents. The sample included 17 residents, with four residents reviewed for wounds. Based on observation, interview, and record review, the facility failed to provide the necessary wound care and services in accordance with professional standards of practice, including wound assessments at least weekly, including measurements and description, for Resident (R) 58 and R2. This placed R58 and R2 at risk for related complications and delayed healing.Findings included:-R58's Electronic Health Record (EHR) revealed a diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypothyroidism (a condition characterized by hyperactivity of the thyroid gland), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), pressure ulcer Stage 3 (full-thickness pressure injury extending through the skin into the tissue below), cellulitis of left lower limb (skin infection caused by bacteria), foot drop right foot and foot drop left foot (inability or difficulty in moving the ankle and toes upward). R58’s admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The assessment documented R58 had impairment to her lower extremities and used a walker and wheelchair for mobility; she required supervision or touching assistance for oral, toileting, and personal hygiene, partial to moderate assistance for bathing and dressing activities of daily living (ADLs), and substantial to maximum assistance with putting on footwear. R58’s “Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA),” dated 07/06/25, recorded that R58 required ADL assistance for self-care and mobility activities. R58’s “Pressure Ulcer/Injury CAA,” dated 07/06/25, recorded R58 was at risk for developing pressure ulcers, and she had one or more unhealed pressure ulcer(s) at Stage 2 or higher. R58’s “Care Plan,” dated 07/11/25, recorded that she had a pressure ulcer on the first and second digit of the right foot. The care plan directed staff to monitor laboratory results for indications of malnutrition, nutritional intake, and skin redness (specifically over bony prominences). The plan directed staff to follow the wound care protocol and perform weekly skin assessments and skin care per facility guidelines, as needed. R58’s EHR revealed an order dated 07/03/25 for a Licensed Weekly Nurse Skin Assessment to be performed every Thursday night shift. R58’s EHR revealed no “Licensed Weekly Nurse Skin Assessment” performed on 07/03/25 or 07/10/25. R58’s “Licensed Weekly Nurse Skin Assessment” performed on 07/17/25 recorded that the foot was noted to have significant improvement with the dressing in place, clean/dry/intact (CDI), but recorded no measurements. R58’s “Licensed Weekly Nurse Skin Assessment” performed on 07/25/25 recorded that the dressing was intact to the foot with no drainage or heat palpated at the time, and no increased foul odor was present, and treatment was in place. There were no wound measurements recorded. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R58’s “Licensed Weekly Nurse Skin Assessment” performed on 08/01/25 had no documentation recorded. On 08/04/25 at 04:03 PM, R58 was sitting in her recliner with her feet elevated, wearing sneakers, and reported she had a wound on one of her big toes that had been treated by staff. R58 reported that she did not want her shoes removed to allow wound observation. On 08/06/25 at 10:30 AM, Licensed Nurse (LN) H reported that wound assessments were supposed to include measurements, a visual description of the wound and surrounding tissue, any changes in the wound, drainage, and description of bandage appearance. On 08/06/25 at 03:05 PM, Administrative Nurse D stated there were no wound assessments for R58’s toe wound, only the “Licensed Weekly Nurse Skin Assessment.” Administrative Nurse D confirmed that the order start date for the “Licensed Weekly Nurse Skin Assessment” was 07/03/25 and further confirmed that the weekly assessments were not started by the nurses until 07/17/25. Administrative Nurse D further stated that there were no measurements of the wound in any of the assessments and that there was no documentation in the 08/01/25 assessment. The facility did not provide a policy related to pressure ulcer monitoring. -R2 's Electronic Medical Record (EMR) revealed a diagnosis of mild protein-calorie malnutrition and cachexia (a complex condition characterized by significant weight loss, muscle wasting, and overall weakness) R2’s 05/20/25 “5-day PPD Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS documented R2 had two Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) pressure ulcers and one Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer that were present on admission. R2’s Care Plan documented R2 was at risk for potential compromise to her skin integrity, initiated on 04/25/25. The plan directed staff to do weekly skin assessments per facility protocol. Staff were also to check the skin routinely with care. The care plan did not indicate a history or present skin concerns. The care plan did not indicate any preventative measures for pressure sores or skin conditions. R2’s Physician Order noted an order to apply a foam-padded Tegaderm (clear transparent dressing) in front of a padded Duoderm (wafer-type moisture-retentive wound dressing used for partial and full-thickness wounds leaking fluids). Change every five days and/or as needed if soiled. Apply on the night shift to the coccyx (area over the tailbone) for prevention; dated 07/01/25. R2’s “Licensed Weekly Skin assessment dated [DATE], on admission, documented a coccyx wound that was a pressure ulcer. No measurements or wound descriptions were documented. R2’s “Licensed Weekly Skin assessment dated [DATE] documented a sacrum (area over the tailbone) wound that was a pressure ulcer. No measurements or wound descriptions were documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2’s “Skilled Evaluation” dated 07/30/25, documented a Stage 2 pressure ulcer that was present on admission. No measurements or wound descriptions were present. R2’s “Skilled Evaluation” dated 08/03/25, documented a Stage 2 pressure ulcer that was present on admission. No measurements or wound descriptions were present. R2's EMR lacked evidence of wound measurements, wound bed evaluation, and effectiveness of treatments. On 08/05/25 at 01:43 PM, Licensed Nurse (LN) H applied gloves. She removed R2’s brief and cleaned the area with a wipe. She stated it looked much better, and said she called the provider and got the wound treatment order changed from a Duoderm to a cream because it had closed that day. Observation of the area revealed it was blanchable and had no open area. LN H applied the cream and removed her gloves. On 08/05/25 at 01:43 PM, LN H stated she went into R2’s room earlier and removed the Duoderm to change the dressing. She noted the wound was closed and called the doctor to ask if he wanted to continue the Duoderm for prevention or discontinue it. LN H received the order to discontinue the Duoderm and apply a cream. LN H stated she was not aware how long R2’s bottom had had the pressure ulcer, but it had been there longer than two months. On 08/05/25 at 9:07 AM, Administrative Nurse D stated that R2 entered the facility with pressure areas on admission. Staff were to complete a “Licensed Weekly Skin Assessment and document measurements, the condition of the wound bed, and any changes weekly. Administrative Nurse D stated she was unable to tell from the documentation if it was healed and returned or if it was not healed. Admin Nurse D verified there were no measurements or descriptions of the wounds documented on the “Licensed Weekly Skin Assessments. The facility did not provide a policy related to pressure ulcer monitoring.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility identified a census of 59 residents with two medication rooms, three medication carts, and two treatment carts. All five carts have a narcotic box. Based on observation, interview, and record review, the facility failed to adequately reconcile the medication cart for controlled substances. This placed the residents at risk for misappropriation. Findings include:- On 08/04/25 at 12:30 PM, the cart in the east hallway contained a lock box that contained controlled substances. Review of the controlled substance reconciliation log lacked evidence of a controlled substance reconciliation between two staff on 07/03/25 at 08:00 PM; only the day shift nurse signed off. The log lacked evidence that a reconciliation was completed on 08/04/25 at 06:00 AM shift. There were no signatures present. On 08/04/25 at 12:30 PM, Certified Medication Aide (CMA) S stated the narcotics should be counted and verified every time the cart changes hands. CMA S said the outgoing nurse, the on-coming nurse, and the CMA all sign for the accuracy of the controlled substances on the cart.On 08/06/25 at 02:19 PM, Administrative Nurse D stated the narcotic medications should be counted and adequately reconciled when the cart changes hands. The facility's policy Controlled Substance Administration and Accountability documented that two nurses account for all controlled substances and access keys at the end of each shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 59 residents, three medication carts, two treatment carts, and two medication rooms. Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals used in the facility were labeled, stored, and secured adequately. This placed the affected residents at risk for ineffective medication regimens or diversion.Findings included:- During an observation on [DATE] at 12:30 PM in the east hall, a medication cart was unlocked and unattended. The cart contained various medications, including Talzenna (a cancer medication), Gabapentin (a medication to relieve nerve pain), and narcotics in a lock box. On [DATE] at 01:03 PM, the east treatment cart was observed. The top drawer contained Novolog (a short-acting insulin that lowers the level of glucose in the blood) that was opened on [DATE]. This would have expired on [DATE]. It also contained Tresiba (long-acting insulin) and Lantus (long-acting insulin) that were not dated when they were opened, so staff were unable to tell when they expired. On [DATE] at 12:30 PM, Certified Medication Aide (CMA) S stated the cart should always be locked when staff are not present with the cart.On [DATE] at 01:03 PM, Licensed Nurse (LN) I stated the insulin multi-use pens were to be dated when they were opened.On [DATE] at 02:19 PM, Administrative Nurse D stated she expected the staff to lock the cart if they were not in the cart. Administrative Nurse D stated the nurse should date the insulin pens when they are opened.The facility's policy Medication Storage dated 2025 documented that all medications and biologics are to be kept in locked compartments. Scheduled two medications are to be kept under a double lock.

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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. (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 reported a census of 59 residents, one main kitchen, and two kitchenettes. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for foodborne bacteria. This placed the residents at risk of foodborne illnesses.Findings included:- During an initial tour of the kitchen on 08/04/25 at 11:04 AM, the following areas of concern were noted:The microwave in the dining room was heavily soiled with dried-on food debris on the inside and outside of the microwave oven.The window area used to pass dirty dishes from the dining room to the kitchen had a heavy build-up of dried-on food and liquid on the frame of the window, the cove base underneath the window, and the trash can next to the window had dried-on food substance. The window area used to pass resident plates from the kitchen into the dining room had a heavy build-up of dried-on food and liquid. The stationary can opener had a build-up of a moist food substance on the base of the opener. The preparation table next to the stove, used to store pots and pans, had food debris on the bottom shelf. A three-tiered cart used to hold eggs, cheese, and clean plates during the preparation of breakfast had non-breakfast food debris on all three tiers. Two plastic containers used to hold individual packets of creamers and sugars had a build-up of grime on the lids. Three plastic containers used to hold flour, sugar, and breadcrumbs had a build-up of grime and a sticky substance on the lids. A large roast sat in a four-inch baking dish, thawing at room temperature. Observation of the three-door reach-in refrigerator revealed the following areas of concern:A one-half gallon of sour cream was opened and undated.A quart container of liquid eggs was opened and undated. A one-half-gallon container of peaches had an unidentified dried-on food substance. A one-gallon container of mayonnaise had an unidentified dried-on food substance.A nearly empty one-gallon container of mustard had an unidentified dried-on food substance and a heavy build-up of dried mustard around the lip of the container. A one-gallon container of salsa had spilled through the wire racks of the reach-in refrigerator onto three one-gallon containers of milk. The container of salsa had spilled onto the bottom shelf of the refrigerator and out onto the front bottom of the reach-in refrigerator. Observation of the snack area in the dining room revealed the following areas of concern:The front of the counter in front of the juice and coffee machines had dried-on food and liquid substance on four doors and one drawer. The three-tiered snack cart had a build-up of a sticky substance on two of the three tiers. All four wheels of the snack cart had a build-up of food debris and grime.Observation of the resident refrigerator/freezer in the kitchenette area of the dining room had the following areas of concern:A partial quart container of mixed fruit was opened and undated. A quart container of an unknown food-type substance was unlabeled. There were seven 20-ounce (oz) plastic bottles of soda opened and unlabeled. The freezer had four 12-oz cans of soda, which had exploded onto other items in the freezer. Two plastic jugs with a facility shake were undated and unlabeled. One opened quart of ice cream was undated and unlabeled. Two opened one-half-gallon containers of ice cream were undated and unlabeled. Two opened one-gallon containers of vanilla ice cream were undated and unlabeled. One plastic cup of an unknown food-type substance was undated and unlabeled. On 08/04/25 at 08:00 AM, Dietary Staff CC stated she had been thawing the roast on the countertop at room temperature instead of in the sink with cold water.On 08/06/25 at 10:35 AM, Dietary Staff BB confirmed the areas of concern would need to be corrected. Dietary Staff BB stated she would continue with the education of her staff during their monthly staff meetings.The facility policy for Sanitation, revised 10/2008, included: The kitchen and dining areas shall be kept clean and free from rubbish. Surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. The facility policy for Food Safety Requirements, undated, included: Staff shall label and date foods kept in the refrigerator. Approved methods for thawing frozen foods include thawing in the refrigerator, submerging under cold water, thawing in a microwave oven, or as part of a continuous cooking process. Thawing at room temperature is not acceptable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175249	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care Center	1630 W 2nd Street Chanute, KS 66720

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. The facility reported a census of 59 residents. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly by failing to ensure the covers on three of the three dumpsters were kept closed. This deficient practice created a risk of attracting insects and/or rodents. Findings included:- During an initial environmental tour of the kitchen on 08/04/25 at 08:19 AM, observation revealed the lids to three of the three dumpsters outside of the kitchen were left open, with trash on the ground surrounding the dumpsters.On 08/04/25 at 09:15 AM, the lids of the dumpsters remained open.On 08/06/25 at 10:35 AM, Dietary Staff BB stated that staff were to keep the lids of the dumpsters closed at all times.The facility policy for Disposal of Garbage and Refuge undated, included: Dumpsters shall be kept covered when not being loaded. The surrounding areas shall be kept clean so that accumulation of debris and insect/rodent attraction is minimal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175249	A. Building B. Wing	08/06/2025

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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 - Few	Provide and implement an infection prevention and control program. The facility reported a census of 59 residents. The sample included 17 residents. Based on interviews, record reviews and observation, the facility staff failed to implement sanitary storage of breathing treatment devices for Resident (R) 1, R18, and R3, who received nebulized (a device that changes liquid medication into a mist easily inhaled into the lungs) breathing treatments. This deficient practice had the potential to spread infections to the residents in the facility.Findings included:- Observed on 08/04/25 at 01:22 PM, R18 was wearing oxygen; the tubing and humidifier bottle were not dated. Her nebulizer equipment and tubing were sitting loosely on a chair, open to the air, and not dated. R18 reported that her nebulizer is left on her chair open to air regularly.Observed on 08/05/25 at 10:33 AM, R18's nebulizer equipment was sitting on her bedside table on paper towels. R18 reported she had her breathing treatment, and the staff had cleaned and set it on the paper towel to dry. The nebulizer tubing was attached to the machine sitting on the floor and chair; none of the equipment was dated.Observed on 08/05/25 at 11:17 AM, R18's nebulizer mask and treatment container were sitting on the bedside table loosely, not dated.Observed on 08/05/25 at 02:27 PM, R1's nebulizer tubing and mouthpiece sat on his bedside rolling table, attached to the machine with no dates. Observed on 08/06/25 at 09:09 AM, R1's nebulizer tubing and mouthpiece were attached to the machine and sitting on the bedside table with no dates.Observed on 08/06/2025 at 10:23 AM, R18's nebulizer items were still attached to the machine and sitting loosely on her chair.On 08/04/2025 at 01:22 PM, R18 reported that her nebulizer was regularly left on her chair loosely after treatments.On 08/06/2025 at 09:16 AM, Licensed Nurse (LN) G stated that nebulizers and oxygen tubing should have been dated, nebulizers should have been rinsed out and set on a paper towel to dry, and then stored in a bag until next use.On 08/06/2025 at 09:19 AM, R1 reported that his nebulizer had not been rinsed out since he had been there.On 08/06/25 at 01:19 PM, Administrative Nurse D stated that oxygen tubing and nebulizer treatment devices were to be dated and changed out weekly. Upon completion of nebulizer treatments, the delivery device was to be cleaned and placed on a paper towel to air dry.The facility policy Nebulizer Therapy, dated 2025, documented that care of the nebulizer equipment included that it would be cleaned after each use, parts would be disassembled after every treatment, the nebulizer cup and mouthpiece would be rinsed with sterile or distilled water, it would be placed an absorbent towel to air dry and once completely dried the nebulizer cup and mouthpiece would be stored in a zip lock bag.