STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 43 residents with 14 sampled for review. Based on observation, interview, and record review, the facility failed to complete a Significant Change Minimum Data Set (MDS), within 14-days, as required, for two Residents (R)19 and R 44, regarding admission onto hospice care. Findings included: - Review of Resident (R)19 electronic medical record (EMR), revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident's Brief Interview for Mental Status (BIMS) score to be four, indicating severe cognitive impairment. The resident did not have a condition or chronic disease which would result in a life expectancy of less than six months, and she did not receive hospice care during the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/26/24, documented the resident had a diagnosis of dementia. The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. The resident had a condition or chronic disease that could result in a life expectancy of less than six months, and she received hospice care during the assessment period. The care plan, revised 08/13/24, lacked staff instruction regarding hospice care. Review of the resident's EMR revealed the following physician's order: Admit to hospice care for the diagnosis of cerebrovascular disease (the death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), ordered 08/06/24. On 08/20/24 at 01:51 PM, Administrative Nurse D stated the facility was not aware of the need to complete a significant change MDS when a resident admitted to hospice. The facility utilized the Resident Assessment Instrument (RAI) in the completion of MDS's. (continued on next page)

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
	175250	A. Building B. Wing	08/21/2024

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to complete a significant change MDS, within the 14 -days, as required, for this resident who admitted to hospice care. - Review of Resident (R)44's electronic medical record (EMR), revealed a diagnosis of cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed moderate impairment. The resident did not have a condition or chronic disease that could result in a life expectancy of less than six months. He did not receive hospice care during the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/24/24, documented the resident had impaired cognition related to a past CVA. The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed moderate impairment. The resident did not have a condition or chronic disease which would result in a life expectancy of less than six months, and she did not receive hospice care during the assessment period. The care plan, revised 07/25/24, instructed staff the resident received hospice care for end-of-life care and support. Review of the resident's EMR revealed the following physician's order: Admit to hospice care for the diagnosis of cerebrovascular accident (CVA-the death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), ordered 07/02/24. On 08/20/24 at 01:51 PM, Administrative Nurse D stated the facility was not aware of the need to complete a significant change MDS when a resident admitted to hospice. The facility utilized the Resident Assessment Instrument (RAI) in the completion of MDS's. The facility failed to complete a significant change MDS, as required, for this resident who admitted to hospice care.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 43 residents with 14 sampled for review. Based on observation, interview, and record review, the facility failed to complete an accurate assessment/Minimum Data Set (MDS for four residents (R)23, R 37, R 2, and R 13 related to siderails used as restraints. Findings included: - Review of Resident (R)23's undated Physician Orders documented diagnoses which included hypertension (high blood pressure), chronic kidney disease, and heart failure. The Admission Minimum Data Set (MDS) dated [DATE], documented the resident's Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The MDS indicated bedrails not used as restraints (physical restraint are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The Quarterly MDS dated [DATE], documented BIMS score of 15, indicating cognitively intact. The bedrails used as restraint daily. The Quarterly MDS dated [DATE], documented a BIMS score of 15, indicating cognitively intact. The bedrails used as restraint daily. Observation on 08/20/24 at 10:21 AM, revealed the resident as alert and oriented. She sat in her wheelchair and self-propelled her wheelchair about the room. There were bedrails at the head of the resident's bed. On 08/19/24 at 12:10 PM, R 23 reported she requested the bedrails at the head of her bed. The bedrails did not restrict her movement in any way. She reported she used the bedrails to reposition herself in the bed and she would object to their removal. On 08/20/24 at 01:53 PM, Certified Nurse Aide (CNA) N stated the facility did not have any residents that used bedrails as restraints. Residents used bedrails to increase their independence. R 23 preferred to lay in the bed with her legs positioned on a pillow. She used her bedrails to turn side to side. On 08/21/24 at 10:29 AM, Licensed Nurse (LN) G confirmed the resident used the bedrails to position herself in the bed, turn from side to side, and enter and exit the bed. She had full access to her body. The bedrails did not restrict her movements but increased her independence. He stated the facility did not use restraints in the facility. (continued on next page)

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	175250	A. Building B. Wing	08/21/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/24 01:33 PM, Administrative Nurse D confirmed the above findings. She reported the facility did not use bedrails to restrain residents. She stated the MDS Coordinator had inaccurately coded bedrails used daily as a restraint She stated, upon review, inaccurate assessment affected 31 resident's assessments. Administrative Nurse D verified the bedrail use by the resident did not meet the definition of restraints as given in the Resident Assessment Instrument Manual (RAI), which the facility used for guidance to accurately compete the residents MDS. The undated facility policy Bedrails documentation included each resident has the right to be free from any physical restraints. It is the policy of the facility to be restraint-free environment. The facility failed to complete an accurate assessment/Minimum Data Set (MDS for (R)23, related to bedrails used as restraint. - Review of Resident (R)37's undated Physician Orders documented diagnoses which included pain, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) with current pathological fracture (broken bone caused by disease). The Admission Minimum Data Set (MDS) dated [DATE], documented the resident's Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The MDS indicated bedrails not used as restraints (physical restraint are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The Quarterly MDS dated [DATE], documented BIMS score of one, indicating severe cognitive impairment. The bedrails used as restraint daily. The Quarterly MDS dated [DATE], documented BIMS score of one, indicating severe cognitive impairment. The bedrails used as restraint daily. Observation on 08/19/24 at 12:36 PM, revealed the resident's bed with bedrails at the head of the bed. On 08/19/24 at 12:10 PM, upon inquiry 37 reported she could move around without limitation. The bedrails helped her to move around. On 08/20/24 at 01:53 PM, Certified Nurse Aide (CNA) N stated the facility did not have any residents that used bedrails as restraints. Residents used bedrails to increase their independence and self-position when in the bed. R 37 used her bedrails to enter and exit the bed independently. The resident is impulsive but the bedrails help her with her balance when she gets in and out of bed independently. On 08/21/24 at 10:29 AM, Licensed Nurse (LN) G confirmed the resident used the bedrails to position herself in the bed, turn from side to side, and enter and exit the bed. She had full access to her body. The bedrails did not restrict her movements but increased her independence. He stated the facility did not use restraints in the facility. LN G reported the resident was impulsive and moved around the room getting in and out of bed independently. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/24 01:33 PM, Administrative Nurse D confirmed the above findings. She reported the facility did not use bedrails to restrain residents. She stated the MDS Coordinator had inaccurately coded bedrails used daily as a restraint. She stated, upon review, inaccurate assessment affected 31 resident's assessments. Administrative Nurse D verified the bedrail use by the resident did not meet the definition of restraints as given in the Resident Assessment Instrument Manual (RAI), which the facility used for guidance to accurately compete the residents MDS. The undated facility policy Bedrails documentation included each resident has the right to be free from any physical restraints. It is the policy of the facility to be restraint-free environment. The facility failed to complete an accurate assessment/Minimum Data Set (MDS for (R)37 related to bedrails used as restraint. 28560 - Review of Resident (R) 2's medical record revealed diagnoses that included femur (long bone in the thigh) fracture and chronic obstructive pulmonary disease (COPD progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive status. The resident had no devices used as a restraint. The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 04/08/24, assessed the resident with no weight bearing of the right extremity and on a turning and repositioning program with a pressure reducing mattress on her bed. The Quarterly MDS, dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13 which indicated normal cognitive status. The resident used a restraint of bed rails daily. The Care Plan reviewed 08/01/24, instructed staff the resident use side rails for mobility and independence. The Siderail Use and Risk Assessment, dated 04/04/24, assessed the resident used two bed rails for the promotion of resident mobility, positioning, and independence. The device assisted to maintain proper body alignment. Observation, on 08/19/24 at 1:11 PM, revealed the resident seated in her recliner in her room. The bed contained two quarter rails. Interview with the resident at that time revealed she had been bed bound for a while due to femur fracture, but now received therapy. The resident stated she used the rails to help turn and reposition when in bed, but now slept in her recliner. Interview, on 08/19/24 at 1:30 PM, with Administrative Nurse D and Administrative Staff A, revealed the facility was restraint free, and confirmed the MDS inaccurately coded the bed rail as a restraint. (continued on next page)

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	175250	A. Building B. Wing	08/21/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Bed Rails undated, instructed staff the facility was to provide a restraint free environment. If a bed rail is used the facility will ensure individual bed rail assessments and evaluations are performed on a regular basis. The facility follows the RAI (Resident Assessment Instrument) Manual for the completion of the MDS. The facility inaccurately assessed this resident's use of side rails as a restraint on the MDS dated [DATE]. - Review of Resident (R) 13's medical record, revealed diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderately impaired cognitive status. The resident utilized two bed rails as a physical restraint daily. The Cognitive Loss Care Area Assessment (CAA) dated 01/11/24, assessed the resident utilized bed rails for positioning assistance. The Quarterly MDS dated [DATE],assessed the resident daily use of bed rail as a restraint. The Quarterly MDS dated [DATE], assessed the resident daily use of bed rail as a restraint. The Care Plan reviewed 06/25/24, instructed staff the resident used side rails for independence and mobility. The Siderail Use and Risk Assessment, dated 04/06/24 and 07/09/24, assessed the resident utilized bed rails to maintain proper body alignment. Observation, on 08/20/24 at 09:13 AM, revealed the resident positioned in bed with two quarter bed rails in the down position. Certified Nurse Aide (CNA) O and P used a draw sheet to turn and reposition the resident to prepare for transfer with a mechanical lift. CNA P stated the resident did not usually assist staff to turn with the use of side rails. Interview, on 08/21/24 at 01:00 PM, with Administrative Nurse D, confirmed the MDS coding of the bed rail as a restraint was inaccurate. Administrative Nurse D stated the facility was restraint free. The facility policy Bed Rails undated, instructed staff the facility was to provide a restraint free environment. If a bed rail is used, the facility will ensure individual bed rail assessments and evaluations are performed on a regular basis. The facility follows the RAI (Resident Assessment Instrument) Manual for the completion of the MDS. The facility inaccurately assessed this resident's use of side rails as a restraint on the MDS, dated (continued on next page)

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	175250	A. Building B. Wing	08/21/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/11/24, 04/11/24 and 07/11/24.

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	175250	A. Building B. Wing	08/21/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 43 residents with 14 sampled for review. Based on observation, interview, and record review, the facility failed to complete a comprehensive care plan for one Resident (R)19, regarding admission onto hospice care. Findings included: - Review of Resident (R)19 electronic medical record (EMR), revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident's Brief Interview for Mental Status (BIMS) score to be four, indicating severe cognitive impairment. The resident did not have a condition or chronic disease which would result in a life expectancy of less than six months, and she did not receive hospice care during the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/26/24, documented the resident had a diagnosis of dementia. The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. The resident had a condition or chronic disease that could result in a life expectancy of less than six months, and she received hospice care during the assessment period. The care plan, revised 08/13/24, lacked staff instruction regarding hospice care. Review of the resident's EMR revealed the following physician's order: Admit to hospice care for the diagnosis of cerebrovascular disease (the death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), ordered 08/06/24. On 08/20/24 at 01:51 PM, Administrative Nurse D stated a resident's care plan should include hospice care instructions for the staff. The facility policy for Care Plan Revisions, undated, included: When changes in a resident's condition occurs, the plan of care will be updated timely. The care plan will be revised when a resident or their family makes the decision to accept hospice services. The care plan shall include detailed and comprehensive instructions to staff on which staff from which specific organization provides services and equipment for the care of the resident and support to the family. The facility failed to complete a comprehensive care plan for this resident who admitted to hospice care.

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	175250	A. Building B. Wing	08/21/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 43 resident with 14 residents selected for review, which included two residents reviewed for respiratory needs. Based on observation, interview, and record review, the facility failed to provide appropriate nebulizer equipment for one of the two Residents (R)2. Findings included: - Review of Resident (R) 2's medical record revealed diagnoses that included femur (long bone in the thigh) fracture and chronic obstructive pulmonary disease (COPD progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive status. The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 04/08/24, assessed the resident with COPD and slept with the head of the bed elevated due to shortness of breath when lying flat. The Care Plan reviewed 08/01/24, instructed staff the resident received oxygen therapy and to observe for signs and symptoms of oxygen deprivation and assess lung sounds as needed. The resident may receive inhalers and breathing treatments in dining area/public areas if she chose. A Physician Order dated 08/18/24, instructed staff to administer ipratropium-albuterol (medications used to dilate airways) breathing solution for nebulization (a technique that require a machine and mask or handheld mouthpiece that turns liquid medication into a mist to inhale into the lungs), 0.5 milligrams (mg)-3 mg (2.5 mg base)/3 ml, every six hours, through 08/20/24. Review of the Medication/Treatment Administration Record dated August 2024, revealed the resident received administration of the ipratropium-albuterol medication on 08/18/24 at 12:00 PM and 06:00 PM, and on 08/19/24 at 06:00 AM (12:00 PM not administered due to wrong size mask) and 09:26 PM (15 and a half hours later). A Nurse Note dated 08/19/24 at 02:31 PM, notified the physician of a delay in providing the breathing treatment due to unavailable supplies. A Physician Order dated 08/20/24, instructed staff to administer the above order through 08/23/24. Observation, on 08/19/24 at 12:47 AM, revealed Certified Medication Aide (CMA) M, prepared to administer the ipratropium-albuterol medication for nebulization. CMA M noted the mask used to place over the resident's nose and mouth was a pediatric (child) size and did not fit the resident appropriately to ensure R2 received the full benefit of the medication. CMA M searched the facility for an appropriately sized mask or handheld inhalation device and was unable to locate one. Interview, on 08/19/24 at 02:18 PM with Licensed Nurse G, confirmed the facility received pediatric masks instead of the ordered adult masks. (continued on next page)

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	175250	A. Building B. Wing	08/21/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 08/19/24 at 04:30 PM, with Administrative Nurse D, revealed staff obtained the appropriate nebulizer supplies through a local retailer. The facility policy Nebulizer Treatment undated, instructed staff to provide safe and effective delivery of medication to the trachea (windpipe the connection from the voice box (larynx) to the lungs, bronchi (two tubes that connect the lungs to the trachea) and or lungs using proper technique and universal precautions. The facility failed to provide proper nebulizer equipment for R2 to ensure optimal effectiveness of ipratropium-albuterol.

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	175250	A. Building B. Wing	08/21/2024

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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. 34056 The facility reported a census of 43 residents. Based on observation, record review and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne bacteria. Findings included: - During an initial tour of the kitchen on 08/20/24 at 07:41 AM, the following areas of concern were noted: 1. The trash can in the dish washing area contained dried-on food and liquid substances on all sides and the lid. 2. The trash can by the hand washing sink contained dried-on food and liquid substances on all sides and the lid. 3. The shelf underneath a preparation table which held plastic pitchers, cutting boards and clean eating utensils, contained food debris. 4. The inside of the microwave contained dried-on food on all sides and the top. 5. Four colored cutting boards contained deep grooves and were discolored. 6. An oscillating fan had a build-up of dust in the slats of the fan. 7. One side of the stove had dried-on food substances. 8. One of two reach-in freezers had a build-up of food substances on the bottom. 9. One of two reach-in freezers had a build-up of food substances on the bottom and a build-up of a black substance in the rubber door seals. 10. Three plastic tubs, beneath a prep table, which held clean cooking utensils, contained a sticky substance on the bottom of the tubs. 11. Five plastic containers on a wire rack which contained clean kitchen utensils, had a heavy build-up of food debris and a sticky substance on the container latches. 12. The table holding the large stand mixer, had a build-up of food substance on the bottom shelf, holding the two large mixing bowls. On 08/21/24 at 10:50 AM, Dietary staff BB confirmed the areas of concern and stated the areas would need to be included on a cleaning schedule. (continued on next page)

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	175250	A. Building B. Wing	08/21/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility lacked a policy for kitchen cleanliness. The facility failed to prepare and serve food under sanitary conditions for the residents of the facility appropriately to prevent the potential for food borne bacterial.