STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175256	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Nursing & Rehabilitation Center	1017 Main Street Osage City, KS 66523

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 39 residents with 18 residents sampled, including two residents reviewed for dignity. Based on observation, interview, and record review, the facility failed to show respect and dignity to one Resident (R)22, when staff failed to assist the resident with changing her clothing when her shirt became soiled with food. Findings included: - Review of Resident (R)22's electronic medical record (EMR) revealed a diagnosis of major depressive disorder (MDD-major mood disorder which causes persistent feelings pf sadness) with psychotic features (major mental disorder characterized by a gross impairment in reality perception). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She had no limitation in range of motion (ROM) and required partial to moderate staff assistance with dressing her upper and lower body. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 09/07/23, documented the resident required extensive assistance of staff with dressing. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 13, indicating intact cognition. She had no limitation in ROM and was independent with dressing her upper and lower body. The care plan, revised 06/12/24, instructed staff the resident was mostly independent with ADLs, but staff were to remind the resident to change her clothing when soiled. Review of the resident's EMR from 08/07/24 through 09/04/24, revealed the resident required supervision to partial staff assistance with dressing. On 09/03/24 at 12:25 PM, the resident sat in a chair in the front commons area. She wore a T-shirt which had dried-on food on the front. On 09/03/24 at 02:27 PM, the resident sat in the front commons area and continued to wear the same dirty top with the dried-on food. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/24 at 09:13 AM, the resident fed herself breakfast in the dining room. While eating, the resident dribbled food onto the front of her clean T-shirt. Following breakfast, the resident went to sit in a chair in the front commons area. On 09/04/24 at 11:47 AM, the resident ambulated to the dining room for lunch. She continued to wear the same dirty T-shirt as she sat down to eat lunch with her peers. On 09/03/24 at 12:25 PM, the resident stated she required staff assistance with changing clothes at times. It was important for her to be neat and clean. On 09/04/24 at 08:45 AM, Certified Nurse Aide (CNA) O stated the resident required assistance with dressing at times. CNA O confirmed the resident's clothing should be changed when soiled with food. On 09/04/24 at 01:07 PM, CNA Q stated the resident required assistance with dressing at times. On 09/04/24 at 02:53 PM, CNA P stated if a resident was wearing dirty clothing, staff would need to prompt her to change. CNA P stated the resident does feed herself and will often dribble food on the front of her shirt. CNA P stated she had seen the resident with food dried to the top of her shirt, but staff did not change her clothing until before the resident went to bed. On 09/04/24 at 03:29 PM, Licensed Nurse (LN) G stated the resident feeds herself and tended to get food on the front of her shirt. Staff should change residents when their clothing became dirty. On 09/05/24 at 09:37 AM, Administrative Nurse D stated it was the expectation for staff to change resident's clothing when they were soiled. The facility policy for Dignity, revised August 2009, included: Each resident shall be cared for in a manner which promotes quality of life, dignity, respect and individuality. The facility failed to assist this resident with changing her clothing when her shirt became soiled with food.

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	175256	A. Building B. Wing	09/05/2024

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36881 The facility reported a census of 39 residents which included 18 residents sampled for review. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for the residents of the facility related to those that used the beauty shop. Findings Included: - On 09/05/24 at 09:32 AM, during tour of the beauty shop with Administrative Staff A the following concerns were identified: 1. The beauty shop lacked an operational negative pressure ventilation fan. 2. The filter on the free-standing dryer filter covered in lint. 3. The workstation cabinet contained unlabeled brush, comb, and a dual hair pick with comb that had hair in the brush bristles and the comb teeth. Administrative Staff A verified the findings above. She agreed the brush, comb, and hair pick was not sanitary and should not be used on multiple residents. Additionally, she stated she did not know what was wrong with the ventilation fan or how long it had not been operational to ensure the resident's comfort when the beautician used chemicals to process resident's hair. The facility lacked a policy to address the above findings to provide a safe, functional, sanitary, and comfortable environment for the residents of the facility related to those that used the beauty shop. The facility failed to provide a safe, functional, sanitary, and comfortable environment for the residents of the facility related to those that used the beauty shop.

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	175256	A. Building B. Wing	09/05/2024

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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 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 39 residents with 18 residents included in the sample. Based on observation, record review, and interview, the facility failed to complete a comprehensive care plan for one Resident (R)12, regarding risk of elopements. Findings included: - Review of Resident (R)12's 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 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. He had wandering behavior one to three days of the assessment period. He had no limitation in range of motion (ROM) and used a walker with supervision while walking 10 to 150 feet. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/23/24, documented the resident had short and long-term memory loss. The Fall CAA, dated 07/23/24, documented the resident had issues with safety awareness. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of four, indicating severe cognitive impairment. He had wandering behavior one to three days of the assessment period. He had no impairment in ROM and used a walker for walking 10 to 150 feet with staff providing verbal cues or touching/steadying assist. The care plan, revised 06/06/24, lacked staff instruction regarding wandering behaviors. Review of the resident's EMR, revealed Elopement Evaluations which placed the resident at a high risk for elopement on 11/29/23, 12/29/23, and 03/02/24. An Elopement Evaluation, completed 06/01/24, put the resident at no risk for elopement. Review of the resident's EMR, on 08/23/24, revealed documentation the resident attempted to elope from an east exit door. Staff redirected the resident. No further documentation was available regarding the event. Review of behavior documentation, from 08/07/24 through 09/05/24, revealed wandering behaviors 13 times. On 09/03/24 at 10:59 AM, the resident sat in the front commons area with his walker in front of him. No wandering behavior noted at that time. On 09/04/24 at 08:55 AM, the resident rested in his room. No wandering behavior noted at that time. (continued on next page)

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	175256	A. Building B. Wing	09/05/2024

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/24 at 01:07 PM, Certified Nurse Aide (CNA) Q stated the resident required staff redirection at times with his cares. CNA Q stated she was unsure if the resident was at risk for elopement and was unsure how to find out which residents were at risk for elopement. On 09/04/24 at 02:53 PM, CNA P stated she was unsure which residents were at risk for elopement and was unsure how to find out which residents were at risk for elopement. On 09/04/24 at 03:17 PM, Housekeeping/Maintenance Staff U stated the resident was not at risk for elopement. Staff would need to review the resident's care plans to know which residents were at risk for elopement. On 09/04/24 at 03:29 PM, Licensed Nurse (LN) G stated elopement assessments were completed upon admission and again if a resident would attempt to elope. If a resident were found to be at a risk for elopement it would be added to the care plan. LN G stated the resident was not at risk for elopement. On 09/05/24 at 09:37 AM, Administrative Nurse D stated the resident did not wander into other resident's rooms. Staff are able to identify which residents are at risk for elopement by looking in the care plans. If a resident had a change in their status in regard to wandering, it would be included in their care plans. The facility policy for Elopements and Wandering Residents, undated, included: The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Interventions to increase staff awareness of the resident's risk will be added to the resident's care plan and communicated to appropriate staff. The facility failed to complete a comprehensive care plan for this resident with staff instruction regarding wandering behaviors and risk of elopement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 39 residents. The sample of 18 residents included eight residents sampled for activities of daily living (ADLs). Based on observation, interview, and record review, the facility failed to ensure necessary services to maintain good personal hygiene for the one sampled Resident (R)27s, related to bathing and shaving. Findings included: - Review of Resident (R) 27's undated Physician's Orders, dated 10/04/23 documentation included diagnoses of chronic kidney disease, diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure) retention of urine, and cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth). The Significant Change of Status Minimum Data Set (MDS) dated [DATE], documented the resident's Brief Interview for Mental Status (BIMS) score of 14 indicated cognitively intact. He did not report any mood indicators. R 27 reported it was very important to make choices regarding bathing and personal hygiene. The resident was without functional limitation in range of motion to upper or lower extremities. He had an indwelling catheter (tubing inserted to drain the bladder) and ostomy (surgical opening through the abdomen to the intestines). He did not receive therapy or restorative nursing programs (RNP). The Quarterly MDS, dated [DATE], lacked changes from above. The Functional Abilities (Self-Care and Mobility Care Area Assessment (CAA), dated 11/09/23, documented the elder had a decline in activities of daily living (ADL) and required staff assistance from to complete his ADL's. The Care Plan, (CP) dated 07/26/24 , directed staff to provide set-up and assistance for shaving during showers. Review of the electronic medical record (EMR) dated 08/31/24 through 09/04/24 documented the resident had not been offered an opportunity to bath and receive a corresponding shave since 08/31/24. On 09/04/24 at 09:27 AM, Resident (R)27 sat in the wheelchair with scraggly facial hair approximately one fourth of an inch or more covering his face and chin and upper lip. His overall appearance was unkept. On inquiry, he reported would like to get shaved because food gets caught in his beard. He stated he liked a trimmed mustache but liked his face shaved. The staff were told to get a mirror and put on the side of the sink and get an electric razor. The nurses tried to get the certified nurse aides (CNA's) to teach him how to stand in front of the mirror and shave, because the mirror was not low enough to see to shave while he sat in his wheelchair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staff shaved him last on Tuesday, 08/27/24 (seven days prior). R 27 stated he needed an electric razor and mirror to shave himself the only facial hair he wanted was a mustache which he wanted trimmed. His beard was shaggy, and he would have to cut his beard with the scissors so he could eat. Additionally, he reported he would prefer bathing after lunch and prior to supper on Monday, Wednesday, and Saturday. On 09/04/24 at 10:26 AM, CNA Q verified the resident needed staff to help with his ADLs which included baths and shaving. She reported the resident should get shaved on his scheduled shower days and as needed between showers and receive showers according to his preferences. CNA Q reported the facility staff had access to a razor for shave on shower days of his choice. He could shave himself with a regular shaver. Staff have a razor in the shower room for use to shave the residents. On 09/04/24 at 02:05 PM, Licensed Nurse (LN) G stated staff should bath residents and provide personal hygiene according to the resident's preferences and should provide assistance and set up for shaving when needed. She reported R 27 required staff assistance with his ADLS to include bathing and shaving. Residents should bathe according to their preferences and should be shaved on their scheduled shower days and in between shower days if needed. Verified resident needed a shave. On 09/04/24 at 02:51 PM, Administrative Nurse D verified R27 required assistance with his ADLS which included set up and assist with shaves. She reported his bathing preferences should be considered when his schedule was set up. She reported the staff should assist R27 with his shaves with his baths and or when needed between his scheduled bath days. The facility policy Activities of Daily Living (ADLs), dated 10/2022, documentation included a resident who is unable to carry out activities of daily living will receive the necessary services to maintain grooming and personal hygiene. The facility failed to ensure necessary services to maintain good personal hygiene for this resident related to bathing and shaving.

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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** 28560 The facility reported a census of 39 residents with 18 residents selected for review, which included one resident reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure sanitary pressure ulcer care for Resident (R)1. Findings included: - Review of Resident (R)1's medical record revealed diagnoses that included multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), urinary incontinence and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident had one stage three pressure ulcer (full thickness pressure injury extending through the skin into the tissue below) present upon admission and one surgical wound. The resident was always incontinent of bowel and bladder. The resident received hospice services. The Pressure Ulcer Care Area Assessment (CAA), dated 08/12/24, assessed the resident with a pressure ulcer and surgical wound. Contributing factors included incontinence, pain, and impairment of mobility. The Care Plan reviewed 08/12/24, instructed staff R1 was incontinent of bowel and bladder and required repositioning and brief change every two hours. The resident had history of moisture associated skin damage with skin breakdown to heels and the gluteal fold (area beneath the buttocks) The resident had muscle atrophy (wasting or decrease in size of a part of the body) with spasms and schizophrenia with behaviors. A Physician Order dated 08/09/24 instructed staff to cleanse the inferior sacrum (lower part of the spine just above the buttock) wound with wound cleanser, apply collagen (a substance that enhances wound healing) particles to the base of the wound and secure with bordered foam dressing daily and as needed. A Physician Order dated 08/26/24, instructed staff to cleanse the left ischium wound (area beneath the buttock cheek) with wound cleanser and apply calcium alginate (a substance that forms a gel on the surface of the wound which absorbs moisture) to the wound bed and apply an absorbent dressing. (continued on next page)

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	175256	A. Building B. Wing	09/05/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 09/04/24 at 09:10 AM, revealed Certified Nurse Aide (CNA) O and CNA N transferred R1 from her broda chair (a type of pressure relieving wheelchair) with a full body mechanical lift into her bed. CNA O stated she did not know if the resident was on Enhanced Barrier Precautions (EBP) and neither CNA O nor CNA N donned Personal Protective Equipment (PPE). CNA O and N then observed the resident was incontinent of urine and positioned the resident onto her side. The resident lacked dressings to her sacrum and ischium. CNA O stated Licensed Nurse G would need to apply the dressings. Observation, on 09/04/24 at 09:22 AM, revealed LN G and LN H, donned gowns, gloves, and masks, and entered R1's room to provide wound care. LNG stated the resident was on EBP due to wounds, and CNA should have donned PPE and did not know how long the wounds were without dressings. LN G cleansed the ischial wound with wound cleanser and noted the wound had a beefy red appearance and was approximately 3 by 2 Centimeters (cm). LN G then changed gloves without sanitizing her hands and cleansed the sacral wound which was yellow/white in color and approximately 0.5 by 1 cm. LN G changed gloves and applied calcium alginate and telfa (a type of gauze that does not adhere to a wound) to the ischial wound and with the same gloves, applied calcium alginate to the sacral wound and covered the area with telfa. Interview on 09/05/24 at 08:30 AM, with Administrative Nurse D, revealed she would expect staff to ensure dressings remained intact to the resident's pressure ulcer and surgical wound and provide wound care with appropriate hand hygiene, gloving and PPE for EBP as required. The facility policy Clean Dressing Change dated 2023, instructed staff to wash hands and put on clean gloves after removing the soiled dressing, after cleansing the wound, and prior to applying medication and dressing. The facility failed to ensure staff provided sanitary wound care to R1's sacral pressure ulcer and ischial surgical wound to prevent infection and enhance wound healing.

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	175256	A. Building B. Wing	09/05/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 39 residents with 18 sampled, including three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to initiate interventions to ensure a safe and secure environment for one Resident (R)12, with a history of wandering behaviors. Findings Included: - Review of Resident (R)12's 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 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. He had wandering behavior one to three days of the assessment period. He had no limitation in range of motion (ROM) and used a walker with supervision while walking 10 to 150 feet. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/23/24, documented the resident had short and long-term memory loss. The Fall CAA, dated 07/23/24, documented the resident had issues with safety awareness. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of four, indicating severe cognitive impairment. He had wandering behavior one to three days of the assessment period. He had no impairment in ROM and used a walker for walking 10 to 150 feet with staff providing verbal cues or touching/steadying assist. The care plan, revised 06/06/24, lacked staff instruction regarding wandering behaviors. Review of the resident's EMR, revealed Elopement Evaluations which placed the resident at a high risk for elopement on 11/29/23, 12/29/23, and 03/02/24. An Elopement Evaluation, completed 06/01/24, put the resident at no risk for elopement. Review of the resident's EMR, on 08/23/24, revealed documentation the resident attempted to elope from an east exit door. Staff redirected the resident. No further documentation was available regarding the event. Review of behavior documentation, from 08/07/24 through 09/05/24, revealed wandering behaviors 13 times. On 09/03/24 at 10:59 AM, the resident sat in the front commons area with his walker in front of him. No wandering behavior noted at that time. On 09/04/24 at 08:55 AM, the resident rested in his room. No wandering behavior noted at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/24 at 01:07 PM, Certified Nurse Aide (CNA) Q stated the resident required staff redirection at times with his cares. CNA Q stated she was unsure if the resident was at risk for elopement and was unsure how to find out which residents were at risk for elopement. On 09/04/24 at 02:53 PM, CNA P stated she was unsure which residents were at risk for elopement and was unsure how to find out which residents were at risk for elopement. On 09/04/24 at 03:17 PM, Housekeeping/Maintenance Staff U stated the resident was not at risk for elopement. Staff would need to review the resident's care plans to know which residents were at risk for elopement. On 09/04/24 at 03:29 PM, Licensed Nurse (LN) G stated elopement assessments were completed upon admission and again if a resident would attempt to elope. If a resident were found to be at a risk for elopement it would be added to the care plan. LN G stated the resident was not at risk for elopement. On 09/05/24 at 09:37 AM, Administrative Nurse D stated the resident did not wander into other resident's rooms. Staff are able to identify which residents are at risk for elopement by looking in the care plans. If a resident had a change in their status in regards to wandering it would be included in their care plans. The facility policy for Elopements and Wandering Residents, undated, included: The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Interventions to increase staff awareness of the resident's risk will be added to the resident's care plan and communicated to appropriate staff. The facility failed to initiate interventions to ensure a safe and secure environment for this resident with a history of wandering behaviors.

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	175256	A. Building B. Wing	09/05/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 39 residents. The sample of 18 residents included four residents reviewed for indwelling catheter and incontinence care/treatment. Based on observation, interview, and record review, the facility failed to provide catheter care/and treatment to prevent infection for four residents with indwelling catheters, Residents (R)27, R 14, R16, and R 2. Findings included: - Review of Resident (R) 27's undated Physician's Orders, dated 10/04/23 documentation included diagnoses of chronic kidney disease (CKD), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure) retention of urine, and cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth). The Significant Change of Status Minimum Data Set (MDS) dated [DATE], documented the resident's Brief Interview for Mental Status (BIMS) score of 14 indicated cognitively intact. He did not report any mood indicators. R 27 was without functional limitation in range of motion to upper or lower extremities. He had an indwelling catheter (tubing inserted to drain the bladder) and ostomy (surgical opening through the abdomen to the intestines). The Quarterly MDS, dated [DATE], lacked changes from above. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 11/09/23, documented the resident had an indwelling catheter and was dependent on staff for toileting and personal hygiene which included catheter care. The Care Plan, (CP) dated 07/26/24 documentation included the resident at risk for infection due to catheter/colostomy use and CKD. He had sepsis (infection in the blood that spreads throughout the body) in the past year with stent placement and removal. The staff should change and care for his urinary catheter and colostomy per physician orders and facility protocol. Review of the residents Task: Catheter Care, documentation in the electronic medical record (EMR) dated revealed catheter care dated 08/13/24 through 08/31/24, staff provided daily catheter care for six out of eighteen (18) days. On 09/04/24 at 07:35 AM, R 27 sat in the wheelchair at the dining table. His urinary catheter tubing laid directly on the floor beneath the wheelchair. The resident's left shoed foot rested in direct contact on top of the urinary catheter tubing. On 09/04/24 at 09:27 AM, resident sat in his wheelchair beside the bed. He lacked an anchor or leg strap to position his catheter to prevent injury from the catheter tugging at the insertion site. He reported staff told him they did not have the anchors available on occasion. Additionally, the resident reported he had been treated for recurrent urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175256	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Nursing & Rehabilitation Center	1017 Main Street Osage City, KS 66523

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/04/24 at 12:44 PM, Certified Nurse Aide (CNA) NN stated the staff should position the resident's catheter bag and tubing below the bladder and off the floor to prevent infection. Additionally, the resident should be provided an anchor on his thigh to position the catheter to prevent injury to the resident. On 09/04/24 at 02:05 PM, Licensed Nurse (LN) G stated staff should position the resident's catheter bag and tubing below the bladder and place the urinary collection bag inside the dignity bag to prevent the tubing and bag from direct contact with the floor. Additionally, the resident should be provided an anchor on his thigh to position the catheter to prevent injury to the resident. On 09/04/24 at 02:51 PM, Administrative Nurse D stated staff should position the resident's catheter bag and tubing below the bladder and placed the urinary collection bag inside the dignity bag to prevent the tubing and bag from direct contact with the floor. Additionally, the resident should be provided an anchor on his thigh to position the catheter to prevent injury to the resident. The facility policy Catheter Care), dated 10/2022, documentation included it is the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care. The facility failed to provide catheter care/and treatment to prevent infection for this resident with an indwelling catheter. - Review of Resident (R) 14's undated Physician's Orders, dated 08/23/24 documentation included diagnoses of chronic kidney disease (CKD), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), retention of urine, and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Admission Minimum Data Set (MDS) dated 01/17/24, documented the resident's Brief Interview for Mental Status, (BIMS) score of 12 indicated moderate cognitive impairment. He was without functional limitation in range of motion to upper or lower extremities. He had an indwelling catheter (tubing inserted to drain the bladder). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 11/09/23, documented the elder had a suprapubic indwelling catheter (S/P catheter-tubing surgically placed through the abdominal wall to the bladder) and was dependent on staff for toileting which included catheter care. The Care Plan (CP) dated 07/15/24, directed staff the resident had a suprapubic catheter and was at risk for infection due to catheter use and CKD The staff should change and care for his urinary catheter per physician orders and facility protocol. On 09/03/24 at 01:52 PM, the resident sat in the wheelchair with six to eight inches of the catheter tubing that dragged on the floor as he self-propelled his wheelchair to the smoking area. On 09/05/24 at 12:56 PM, the resident was in his bed on his left side with the catheter tubing placed through his jogging pants leg positioned below his bladder off the floor. (continued on next page)

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	175256	A. Building B. Wing	09/05/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/04/24 at 12:44 PM, Certified Nurse Aide (CNA) NN, reported the staff should position the resident's catheter bag and tubing below the bladder and off the floor to prevent infection. On 09/04/24 at 02:05 PM, Licensed Nurse (LN) G stated staff should position the resident's catheter bag and tubing below the bladder and place the urinary collection bag inside the dignity bag to prevent the tubing and bag from direct contact with the floor. Additionally, the resident should be provided an anchor on his thigh to position the catheter to prevent injury to the resident. On 09/04/24 at 02:51 PM, Administrative Nurse D stated staff should position the resident's catheter bag and tubing below the bladder and placed the urinary collection bag inside the dignity bag to prevent the tubing and bag from direct contact with the floor. The facility policy Catheter Care, dated 10/2022, documentation included it is the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care. The facility failed to provide catheter care/and treatment to prevent infection for this resident with a suprapubic indwelling catheters. 34056 - Review of Resident (R)2's electronic medical record (EMR) included the following diagnoses: neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying) and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. He had limited range of motion (ROM) to his bilateral (both) lower extremities, had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was dependent on staff for toileting hygiene. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 11/10/23, documented the resident had a suprapubic catheter (a flexible tube that drains urine from the bladder through a small incision in the lower abdomen, above the pubic bone) and was dependent on staff for toileting hygiene. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 13, indicating moderate cognitive impairment. He had limited ROM to his bilateral lower extremities, had an indwelling urinary catheter and was dependent on staff for toileting hygiene. The care plan for activities of daily living (ADL), revised 05/08/24, instructed staff the resident had impaired mobility related to paraplegia. The staff were instructed to ensure the tubing of the urinary catheter was not touching the floor at any time. Review of the resident's EMR revealed the following physician's order: Catheter care, every shift and as needed (PRN), ordered 08/11/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24 at 12:47 PM, the resident sat in his wheelchair in the dining room eating lunch. The catheter tubing underneath his wheelchair rested directly on the floor of the dining room. On 09/04/24 at 09:11 AM, the resident sat in his wheelchair in the dining room eating breakfast. The catheter tubing underneath his wheelchair rested directly on the floor of the dining room. On 09/04/24 at 11:01 PM, the resident propelled himself in his wheelchair down the hall to his room. The catheter tubing underneath his wheelchair drug on the floor. On 09/04/24 at 09:00 AM, Certified Nurse Aide (CNA) Q stated the resident's catheter tubing should not touch the floor. On 09/04/24 at 02:53 PM, CNA P stated the staff were to ensure the resident's catheter tubing stayed inside of the dignity bag and did not drag on the floor. On 09/04/24 at 03:29 PM, Licensed Nurse (LN) G stated staff were to keep the resident's catheter tubing inside of the dignity bag. The catheter tubing should never be on the floor. On 09/05/24 at 09:37 AM, Administrative Nurse D stated the catheter tubing should not be on the floor. Staff were to ensure the tubing was kept inside of the dignity bag. The facility policy for Catheter Care, undated, included: It is the policy of the facility to ensure residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. The facility failed to ensure the catheter tubing for this dependent resident with an indwelling urinary catheter was kept inside of the dignity bag. 28560 - Review of Resident (R)16's medical record revealed diagnoses that included neuromuscular disorder of the bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), chronic kidney disease and congestive heart failure (a condition with low heart output and the body becomes congested with fluid). The Annual Minimum Data Set (MDS) dated [DATE], the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident had a urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The resident utilized a walker and/or wheelchair for mobility and required substantial/maximal assistance for toileting hygiene. The resident could propel her wheelchair independently. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 06/24/24, assessed the resident had an indwelling urinary catheter and required substantial/maximal assistance with toilet transfers and toileting hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan reviewed 06/24/24, instructed staff to ensure the urinary was secure to prevent tugging and place the urine collection pouch in a dignity bag and ensure the tubing did not touch the floor. A Physician's Order dated 12/16/21, instructed staff to provide catheter and peri care every shift. A Physician's Order dated 05/22/24, instructed staff to change the urinary catheter with a size 16 French (Fr) with a 30 Cubic Centimeter (cc) balloon every month and as needed. A Physician's Order dated 08/12/24, instructed staff to ensure a catheter anchor was in place to prevent pulling and tugging of the catheter. Observation, on 09/03/24 at 02:07 PM, revealed the resident seated in her wheelchair, propelling herself from the dining room to her room. Approximately six inches of the catheter tubing lay directly on the floor. Observation, on 09/04/24 at 08:00 AM, revealed the resident seated in her wheelchair, propelling herself to the dining room. Approximately six inches of tubing lay directly on the floor. Observation, on 09/04/24 at 01:36 PM, revealed Certified Nurse Aide (CNA) MM, assisted resident with transfer to the toilet and noted the catheter anchor was not in place and was tangled on the lower portion of the urine drainage tubing. Interview on 09/04/24 at 01:40 PM, with Licensed Nurse (LN) G , revealed she would expect staff to ensure R16's catheter anchor was in place and functioning appropriately. LN G obtained a new catheter anchor for replacement. Observation on 09/04/24 at 01:56 PM, revealed CNA M assisted the resident to transfer from the toilet to her recliner. CNA M stated she did know how to attach a catheter anchor and would notify the nurse to apply a new one. Upon seated in her recliner, approximately six inches of the resident's catheter tubing lay directly on the floor. Interview on 09/04/24 at 02:30 PM with Administrative Nurse D, revealed she would expect staff to ensure catheter tubing was secured with an anchoring device, and maintain the tubing off the floor. The facility policy Catheter Care dated 2021, instructed staff to ensure the catheter anchor was in place to prevent pulling/tugging. Residents with an indwelling urinary catheter receive appropriate catheter care and maintain their dignity and privacy. The facility failed to ensure R16's urinary catheter was securely anchored, and tubing was maintained off the floor to prevent trauma and risk of infection.

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	175256	A. Building B. Wing	09/05/2024

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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 39 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 resident kitchenette, on 09/03/24 at 09:39 AM, the following areas of concern were noted in the facility kitchen: 1. The inside of the microwave contained a dried-on food substance. 2. The stationary can opener contained a build-up of a sticky substance on the area which pierces the can and the handle of the opener. 3. The hand soap dispenser plate had a large amount of a dried, sticky substance. 4. The bottom shelf of one prep table contained food debris. The shelf held three, three-drawer plastic containers with each drawer containing serving utensils. The bottom inside of each of the nine drawers contained dust and small food particles. 5. The tracks of four sliding doors, which contained clean dishes, bowls, plastic containers for food, etc., had a build-up of a black, sticky substance. 6. The insides of the two-door reach-in refrigerator had food debris on the bottom shelf. 7. A wire cart holding clean plates, bowls and plate covers contained ground-in food on all four leg and wheels. The two wire tiers of the cart also contained ground-in food. 8. A wire rack holding clean pots and pans had a build-up of a sticky substance and dust. 9. A plastic three-drawer cart which contained coffee filters, hot chocolate packets and hot tea bags for the residents had a sticky substance on the inside bottom of each of the three drawers. 10. Four of the six wire shelves in the storeroom, used to store food and supplies, contained a build-up of dust. 11. The dish room had three, two door reach-in freezers with food debris on the bottom. One of the freezers contained a build-up of food debris in the rubber door seal. 12. One wire rack that held disposable plates, cups, bowls, napkins and eating utensils had a sticky substance and dust covered the racks. (continued on next page)

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	175256	A. Building B. Wing	09/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. Four plastic rolling carts used to transport clean and dirty dishes had a build-up of food and gunk on all four wheels and the grooves of the handles. On 09/05/24 at 09:34 AM, Administrative staff A stated the dietary staff were responsible for keeping the kitchen clean. The facility lacked a policy for kitchen cleanliness. The facility failed to prepare and serve food under sanitary conditions to the residents of the facility to prevent the potential for food borne bacteria.

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	175256	A. Building B. Wing	09/05/2024

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 34056 The facility reported a census of 39 residents. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly by failing to ensure the lid of the dumpster was kept close. Findings included: - During an initial tour of the kitchen on 09/03/24 at 09:39 AM, observation revealed the lid to the dumpster outside of the kitchen was left open. On 09/04/24 at 10:41 AM, observation revealed the lid to the dumpster outside of the kitchen was left open. On 09/03/24 at 10:00 AM, Dietary staff BB stated it was the expectation for the lids of the dumpster be kept always closed. The facility lacked a policy for keeping the lid of the dumpster closed. The facility failed to ensure the lid of the dumpster was kept always closed, as required.

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	175256	A. Building B. Wing	09/05/2024

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 28560 The facility reported a census of 39 residents. Based on observation, interview, and record review, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 11 dates between 04/01/23 and 06/30/23 and four dates between 07/01/23 and 09/30/23 as required. Findings included: - Review of the Payroll Base Journal (PBJ) Staffing Data Report for fiscal year (FY), Quarter 3, 2023 (04/01/23 thru 06/30/23) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates: On 04/02/23, Sunday (SU), On 04/12/23, Wednesday (WE), On 04/15/23, Saturday (SA), On 04/16/23, SU, On 04/30/23, SU, On 05/13/23, SA, On 05/14/23, SU, On 05/28/23, SU, On 06/17/23, SA, On 06/24/23, SA, and on 06/30/23, Friday (FR). Review of the PBJ for FY, Quarter 4, 2023 (07/01/23-09/30/23), the following infraction dates the facility failed to have Licensed Nursing Coverage 24 hours/day included: On 07/02/23, Sunday (SU), On 07/08/23, Saturday (SA), (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175256	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Nursing & Rehabilitation Center	1017 Main Street Osage City, KS 66523

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/12/23, SA, and On 09/02/23, SA. Interview, on 09/05/24 at 01:29 PM, with Consultant staff HH, revealed the facility initiated a new reporting program to mitigate erroneous calculation of PBJ Licensed Nurse hours. Consultant Staff HH stated it was possible the information regarding licensed nurse hours had not been submitted accurately but the facility did have 24/7 Licensed Nurse coverage. The facility policy for Payroll Based Journal, effective 2022, instructed staff to electronically submit to CMS complete and accurate direct care staffing information, which include information of agency and contract staff based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., Payroll Base Journal (PBJ), related to licensed nursing staffing information when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 11 dates between 04/01/23 and 06/30/23 and four dates between 07/01/23-09/30/23 as required.

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	175256	A. Building B. Wing	09/05/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 39 residents. Based on observation, interview, and record review, the facility failed to ensure staff followed Enhanced Barrier Precautions (EBP) for one Resident (R)1 with chronic wounds to prevent the spread of infection as required. Findings included: - Review of Resident (R)1's medical record revealed diagnoses that included multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), urinary incontinence and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident had one stage three pressure ulcer (full thickness pressure injury extending through the skin into the tissue below) present upon admission and one surgical wound. The resident was always incontinent of bowel and bladder. The resident received hospice services. The Pressure Ulcer Care Area Assessment (CAA), dated 08/12/24, assessed the resident with a pressure ulcer and surgical wound. Contributing factors included incontinence, pain, and impairment of mobility. The Care Plan reviewed 08/12/24, instructed staff R1 was incontinent of bowel and bladder and required repositioning and brief change every two hours. The resident had history of moisture associated skin damage with skin breakdown to heels and the gluteal fold (area beneath the buttocks) The resident had muscle atrophy (wasting or decrease in size of a part of the body) with spasms and schizophrenia with behaviors. A Physician Order dated 08/09/24 instructed staff to cleanse the inferior sacrum (lower part of the spine just above the buttock) wound with wound cleanser, apply collagen (a substance that enhances wound healing) particles to the base of the wound and secure with bordered foam dressing daily and as needed. A Physician Order dated 08/26/24, instructed staff to cleanse the left ischium wound (area beneath the buttock cheek) with wound cleanser and apply calcium alginate (a substance that forms a gel on the surface of the wound which absorbs moisture) to the wound bed and apply an absorbent dressing. Observation, on 09/04/24 at 09:10 AM, revealed Certified Nurse Aide (CNA) O and CNA N transferred R1 from her broda chair (a type of pressure relieving wheelchair) with a full body mechanical lift into her bed. CNA O stated she did not know if the resident was on Enhanced Barrier Precautions (EBP) and neither CNA O nor CNA N donned Personal Protective Equipment (PPE). CNA O and N then observed the resident was incontinent of urine and positioned the resident onto her side. The resident lacked dressings to her sacrum and ischium. CNA O stated Licensed Nurse G would need to apply the dressings. (continued on next page)

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	175256	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Nursing & Rehabilitation Center	1017 Main Street Osage City, KS 66523

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 09/04/24 at 09:22 AM, revealed LN G and LN H, donned gowns, gloves, and masks, and entered R1's room to provide wound care. LNG stated the resident was on EBP due to wounds, and CNA should have donned PPE when providing the transfer and incontinence care. Interview on 09/05/24 at 08:30 AM, with Administrative Nurse D, revealed she would expect staff to follow EBP for R1 due to wounds and had informed staff recently about the procedures for donning and doffing PPE for this resident. The facility policy Enhanced Barrier Precautions dated 2024, instructed staff to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms during high contact resident care activities. The facility failed to ensure staff followed Enhanced Barrier Precautions (EBP) for one Resident (R)1 with chronic wounds to prevent the spread of infection as required.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36881 The facility reported a census of 39 residents which included 18 residents sampled for review. Based on observation, interview, and record review, the facility failed to provide a safe, functional, and sanitary environment in the laundry. Findings included: - The laundry tour, on 09/05/24 at 08:34 AM, with Housekeeping/Laundry staff V revealed environmental concerns which included: 1. Two uncovered soiled linen barrels with soiled linens uncovered in the barrels. 2. The concrete floor throughout the laundry room had missing paint/sealant that exposed bare concrete which was unsanitizable. 3. The wall beside the washing machine with peeling sheetrock and a build-up of grime and dust. 4. The egress from the soiled linen/washroom to the clean linen room had grime build-up and rolled up tape on the floor for with grime and dust stuck to the tape. 5. The table used to fold clean laundry and linen was unsanitizable due to a missing laminate strip on the end of the folding surface, which exposed unsealed bare wood which was not sanitizable. On 09/05/24 at 09:45 AM, Administrative Staff A confirmed the above findings related to environmental concerns noted above. She reported the maintenance man was new and the administration was new but had been working on environmental concerns throughout the facility and she would ensure the maintenance man addressed the above identified laundry concerns. The facility lacked a policy related to maintenance and housekeeping in the laundry. The facility failed to provide a safe, functional, and sanitary environment in the laundry.