| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175280 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/25/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Flint Hills Care and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1620 Wheeler Street Emporia, KS 66801 | |

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) |
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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560<br><br>The facility reported a census of 45 residents with nine residents selected for review, which included four residents reviewed for abuse, neglect, and exploitation. Based on observation, interview and record review, the facility failed to ensure staff were competent in interactions with aggressive behaviors for one Resident (R)9, with dementia.<br><br>Findings included:<br><br>- Review of Resident (R)9's medical record revealed diagnoses that included frontal temporal neurocognitive disorder( sometimes called frontotemporal dementia, which is damage to neurons in the frontal and temporal lobes of the brain which result in unusual behaviors, emotional problems, trouble communicating, difficulty with work, or difficulty with walking), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and moderate dementia (progressive mental disorder characterized by failing memory, confusion)<br><br>with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).<br><br>The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with severely impaired ability to make decisions. The resident received antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) medications. The resident was frequently incontinent of urine and had no impairment in upper or lower extremities.<br><br>The Cognitive Loss Care Area Assessment (CAA), dated 03/24/24, assessed the resident required consistency in care, and staff advised to use cues and reorientation to assist with this. The resident received psychotropic medications (medications that alter mood or thought).<br><br>The Care Plan dated 04/03/24, instructed staff the resident had behaviors of resistance to cares and aggression, and poor impulse control. The care plan instructed staff to calmly walk away from the resident and approach later .<br><br>A Nurse's note, dated 06/22/24 at 02:25 AM, revealed Licensed Nurse I, assessed R9 for signs of abuse and found no redness or bruising or statements of pain.<br><br>(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 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An Intake Detail for Complaint 188743, dated 06/24/24 at 08:50 AM, revealed the facility was investigating an alleged altercation between R9 and Certified Nurse Aide (CNA) M.<br><br>Observation on 06/25/24 at 07:30 AM, revealed the resident seated in his wheelchair in the dining room with his eyes closed. Certified Medication Aide (CMA) R stated the resident was offered food and refused to eat but had taken his crushed medications earlier in the morning. CMA R stated the resident would spit out his medications at times and refused cares.<br><br>Interview, on 06/25/24 at 07:44 AM, with Administrative Nurse D, revealed the resident had aggression, and medication the provider made medication changes. Administrative Nurse D stated staff received training in dementia through computerized and paper courses, but staff would probably benefit with a more interactive approach to training for aggression in residents.<br><br>Observation, on 06/25/24 at 08:05 AM, revealed Certified Nurse Aide (CNA) O, CNA P and Administrative Nurse D, transferred the resident from his wheelchair to recliner in the common living area. The resident required constant cuing and had difficulty following directions for the transfer.<br><br>Interview, on 06/25/24 at 08:30 AM, with CNA O revealed the resident could become aggressive with staff during cares, and the staff should remain calm and walk away from the resident and come back later.<br><br>Interview, on 06/25/24 at 08:45 AM, with Licensed Nurse (LN) H, revealed the resident's dementia worsened and the resident becomes agitated when there is a lot of noise around him. LN H stated the resident did not comprehend what staff were doing when they provided cares and easily became agitated. Staff should wait for the resident to calm down and try again.<br><br>Interview, on 06/25/24 at 08:44 AM, with CNA M, revealed on 06/22/24 at approximately 11:30 PM, she and CNA N (a new trainee) took the resident to his room for incontinence care and to prepare the resident for bed. CNA M stated the resident became uncooperative after transferring him into bed and CNA N left the room to find another staff member for assistance. CNA M stated with the resident positioned in bed, she attempted to remove his shorts and soiled brief. The resident struck his fists at her, yelled, and pulled her hair and caused her to lose her balance and she raised her arms in response to this. CNA M stated she yelled out in pain and the resident continued to yell. CNA N and LN G came into the room and deescalated the situation and completed the tasks.<br><br>Interview, on 06/25/24 at 12:30 PM, LN G revealed on 06/22/24 at approximately 11:45 PM, CNA N requested her assistance with R9. LN G stated she entered R9's room shortly after CNA N and saw R9 hit CNA M with his right hand while CNA M held onto his left hand with both of her hands. The resident continued to attempt to strike at CNA M and kick her. LN G stated she, CNA M and CNA N were able to change the resident out of his wet brief and provide incontinence care with difficulty. LN G stated the resident frequently became aggressive and more training in dealing with this type of behavior would be beneficial for staff and the resident.<br><br>The facility policy Comprehensive Care Plans, reviewed 11/12/23, instructed staff the facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record including discussions with the resident/resident representative. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions.<br><br>(continued on next page) |

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| F 0741<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility failed to ensure staff competency for interactions with aggressive residents and failed to provide person centered training for this resident's resistive behaviors to prevent potential detrimental physical and mental health consequences. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>28560<br><br>The facility reported a census of 45 residents. Based on observation, interview, and record review, the facility failed to ensure staff-maintained food on the steam table at a temperature of at least 135 degrees.<br><br>Findings included:<br><br>- Observation, on 06/24/24 at 12:30 PM, revealed Dietary Staff CC, obtained temperature of the food on the steam table as follows:<br><br>Chicken paprikash had a temperature of 110 degrees Fahrenheit.<br><br>Buttered egg noodles had a temperature of 120 degrees Fahrenheit.<br><br>Interview on 06/24/24 at 12:30 PM, Dietary Staff CC reported she kept the food uncovered while she served the food to the residents. Dietary Staff CC obtained a temperature of the food when she removed it from the oven/cook top which registered 170 degrees Fahrenheit and placed it in the steam table pans but did not obtain the temperature as it was held on the steam table prior to serving the residents.<br><br>Interview on 06/25/24 at 12:05 PM with Dietary staff BB, reported dietary staff had the exhaust fans on and the air conditioner yesterday (06/24/24) and this may have caused the lower food temperatures. Dietary Staff BB confirmed she would expect staff to ensure the holding temperature of the food on the steam table at 135 degrees Fahrenheit.<br><br>The facility policy Food Production and Food Safety, dated 2021, instructed staff the maintain a temperature at or above 135 degrees Fahrenheit during holding distribution and service.<br><br>The facility failed to ensure staff maintained the holding temperature of the food at 135 degrees Fahrenheit on the steam table as required to prevent food borne illness. |