STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175280	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Hills Care and Rehabilitation Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 44 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to identify an elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) as a potential neglect and report to the State Agency (SA) as required. This placed the resident at risk for neglect and impaired safety.Findings included:- Review of the Electronic Health Record (EHR) documented Resident (R)30 had diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), and mood disorder. R30 admitted to the facility on [DATE].R30's 09/15/24 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) of eight, which indicated moderately impaired cognition. The MDS documented R30 required maximal assistance for bathing, transfers, dressing, and toileting. The MDS documented R30 required moderate assistance with oral care, personal hygiene, and bed mobility. The MDS documented R30 was independent with eating and wheelchair mobility. The MDS documented R30 had wandering behaviors daily and placed the resident at significant risk of getting to a potentially dangerous place, like outside the facility.R30's 09/18/24 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R30 had impaired cognitive function/dementia or impaired thought processes related to his dementia. R30 would get agitated when he could not remember what to do or how to do it. R30 would wander looking for different places.R30's 09/18/24 Behavioral Symptoms CAA documented R30 was an elopement risk and wandered aimlessly. R30's information and photo were placed in the elopement book. Staff are aware R30 was a risk for elopement, and his anxiety could cause him to wander.R30's 04/30/25 Quarterly MDS documented a BIMS score of eight, which indicated moderately impaired cognition; no behaviors were noted. The MDS documented R30 was dependent on staff assistance for toileting and required maximal assistance with showers and moderate assistance with lower dressing. The MDS documented R30 was independent with eating and wheelchair mobility.R30's Care Plan dated 09/17/24, documented R30 was at risk for elopement related to cognitive status, mobility status, and assessment indicating a high risk potential for wandering/elopement. The plan directed staff to provide the following interventions:Encourage independence while in the building but ensure supervision while outside.Encourage participation in positive, meaningful activity programs of choice.Engage R30 in active conversation as a form of redirection.In the event of an elopement, follow search and reporting protocols.Keep routine consistent to alleviate confusion.Observe for signs/symptoms of acute illness, which may enhance confusion.Provide picture/identification and description of R30 in the elopement book.Redirect when wandering around doors/exits.Visualize the resident's whereabouts frequently.R30's Wandering/Elopement Risk Scale, dated 09/10/24 and 12/20/24, documented a score of 10.0 which indicated the resident was at risk to wander.R30's Progress Note on 12/22/24 at 01:00 PM, documented upon coming out of the third dining room bathroom, an unknown Licensed Nurse (LN) was notified by an unknown Certified Nurse Aide (CNA) that a family member alerted staff that R30 exited the building through the north side Emporia Lane hallway exit. The note recorded both the LN and CNA ran to the door. The LN entered the door code and ran outside to find R30 in his wheelchair on a street near the facility. The note recorded the LN asked R30 what he was doing, to which he said he was leaving the [expletive] place. The note documented staff found and safely returned R30 into the facility, and elopement procedure was initiated. Staff assessed R30 for pain; he denied any injuries, and none were noted.R30's Risk Management Report dated 12/22/24 at 01:00 PM documented the above note and that R30 was oriented to person but confused with impaired memory; he was an active seeker and wanderer.During an observation on 06/30/25 at 09:40 AM, R30 was noted to be able to self-propel in his wheelchair in the hallway.On 06/29/25 at 01:09 PM, R30's representative reported that R30 was found outside the facility last year and reported she was told he did not leave the facility property. R30's representative reported that she was concerned now that she heard R30 had made it out to the street when he exited the building.During an interview on 06/30/25 at 12:56 PM Administrative Nurse D reported R30 exited the building on 12/22/24 and did not report to the State Agency as she did not feel like the incident was a true elopement. Administrative Nurse D said the resident was in view of a family member of another resident, so R30 really did not elope. Administrative Nurse D reported she did not receive a statement from the family/visitor who reported to the nursing staff that R30 had gone out the door.During an interview on 06/30/25 01:30 PM Administrative Staff A reported that she was told the day R30 exited the facility, the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents, with one resident reviewed for hospitalization. Based on interview and record review, the facility failed to provide a written bed hold policy and failed to issue written notification as soon as practicable for transfers for Resident (R) 32 This placed the resident at risk for impaired rights related to returning to the facility.Findings included:- Review of the Electronic Health Record (EHR), documented R32 had diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right hip, chronic pain, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R32's 02/01/25 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R32 required supervision for bathing and was independent for all activities of daily living (ADL).R32's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 02/18/25, documented R32 required assistance with ADLs related to weakness and shortness of breath. R32 had depression and may have lack of motivation to complete ADLs. R32's 01/12/25 at 12:18 AM Progress Note documented resident was transferred to the hospital due to a large amount of blood in stool.R32's EHR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R32 and/or his representative.On 07/01/25 at 09:43 AM, Licensed Nurse (LN) G reported when a resident was transferred to the hospital, the nurse asked the resident and or representative if they wanted a bed hold. LN G reported there was no form that was completed by the nurse at the time of transfer and said she would notify Social Service Designee (SSD) X, Administrative Nurse D and Administrative Staff A of the transfer.On 07/01/25 at 09:55 AM, SSD X reported there was no bed hold completed when R32 transferred to the hospital on [DATE]. SSD X reported the nurse could complete a Bed-Hold Notification Agreement under the assessment tab in the EHR. Additionally, SSD X reported the bed hold could be completed on the next business day if the form had not been completed the day of transfer. During an interview on 07/01/25 at 10:00 AM, Administrative Staff A she expected the bed-hold to be completed the day of the transfer or the next business day.The facility's Transfer and/ or Discharge, Including Against Medical Advice, Discharge Notification dated 11/08/24 documented to provide a notice of transfer and the facility's bed hold notice to the resident and representative as indicated.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 44 residents; 12 residents were sampled for review. Based on observation, interview, and record review the facility failed to ensure accurate Minimum Data Set (MDS) assessments for Residents (R) 18, R42, and R7 related to urinary continence and/or indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag) and R7 for communication/sensory status. The deficient practice placed the affected residents at risk for impaired care due to unidentified care needs.Findings included:- R18's Electronic Health Records (EHR) documented diagnoses, which included 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).R18's admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating cognitively intact. He had an indwelling catheter and was always continent (able to control bladder/urine flow).The 06/19/25 Urinary Continence Indwelling Catheter Care Area Assessment, (CAA) documented the resident had an indwelling catheter for neurogenic bladder.On 06/29/25 at 03:57 PM, the resident sat in his wheelchair. His catheter tubing was positioned below his bladder. He reported he had an indwelling catheter because he could not completely empty his bladder without it. R18 verified he has had a catheter throughout his stay at the facility.On 07/01/25 at 11:54 AM, Administrative Nurse F verified above findings and reported she always coded the MDS for residents with indwelling catheters as always continent. She stated that the facility used the Resident Assessment Instrument (RAI) manual for guidance to accurately code the MDS. She reviewed the RAI manual, and she confirmed she should code the MDS for residents with catheters as not rated. Administrative Nurse F stated the admission MDS, dated [DATE] was not accurate.The RAI manual, dated 10/2019, documentation included the MDS coding for the number of calendar days in the look-back period should be coded to reflect Code 9, not rated: if during the seven-day look-back period the resident had an indwelling bladder catheter. - R42's Electronic Health Records (EHR), dated 06/01/25, documented diagnoses which included 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).R42's admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating cognitively intact. He had an indwelling catheter and was always continent (able to control bladder/urine flow).The 05/28/25Urinary Continence Indwelling Catheter Care Area Assessment (CAA) documented the resident had an indwelling catheter for urinary retention.On 06/29/25 at 11:49 AM, R42 laid in bed with his catheter positioned through his right pant leg below his bladder.On 07/01/25 at 11:54 AM, Administrative Nurse F verified above findings and reported she always coded the MDS for residents with indwelling catheters as always continent. She stated that the facility used the Resident Assessment Instrument (RAI) manual for guidance to accurately code the MDS. She reviewed the RAI manual, and she confirmed she should code the MDS for residents with catheters as not rated. Administrative Nurse F stated the admission MDS, dated [DATE] was not accurate.The RAI manual, dated 10/2019, documentation included the MDS coding for the number of calendar days in the look-back period should be coded to reflect Code 9, not rated: if during the seven-day look-back period the resident had an indwelling bladder catheter. - R7's Electronic Health Records (EHR) dated 06/01/25, documented diagnoses which included bladder obstruction and hearing loss.The 08/30/24, Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The resident had an indwelling catheter and was always continent (able to control bladder/urine flow).The 09/06/24 Urinary Continence/Indwelling Catheter and Communication Care Area Assessment (CAA) documented he had an indwelling catheter due to urinary retention and a communication problem related to his hearing deficit.R7's 05/26/25 Quarterly MDS documentation included a BIMS score of six, indicating severe cognitive impairment. His hearing was adequate, and he did not wear hearing aids. R 7 had a catheter, and the MDS recorded he was always continent.R7's EHR Physician Orders (POS) documented the following orders:Enhanced Barrier Precautions due to his catheter placement, ordered 11/4/24.Place hearing aid on charger in med room at bedtime, ordered 04/23/25.On 06/30/25 at 03:40 PM, observation revealed R7 returned from his appointment. The resident's hearing aid was not in his ears. Certified Medication Aide (CMA) T found the hearing aids in his bag with his paperwork in the back of his wheelchair. On 07/01/25 at 11:54 AM, Administrative Nurse F verified above findings and reported she always coded the MDS for residents with indwelling catheters as always continent. She stated that the facility used the

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 44 residents. The sample included 12 residents, with one reviewed for hearing aid use. Based on the interview and record review, the facility failed to ensure that dependent Resident (R) 7 received staff assistance in placing his hearing aids. This placed the resident at risk for social isolation, mental decline, and loss of independence. Findings included:- R7's Electronic Health Record (EHR) revealed diagnoses of conductive hearing loss and a need for assistance with personal care. R7's 08/30/24 Annual Minimum Data Set (MDS) documented that the resident had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R7 was dependent on staff for toileting, bathing, dressing, footwear, and personal hygiene. The MDS noted R7 had minimal difficulty with hearing, and R7 used hearing aids. The 09/06/24 Communication Care Area Assessment (CAA) documented R7 had a communication problem related to having difficulty understanding or making his needs known. The CAA noted R7 had hearing deficits and staff would ensure R7 understood what requests were being made. R7's 05/26/25 Quarterly MDS documented a BIMS score of six, which indicated severely impaired cognition. The MDS documented R7's hearing was adequate, and he had no hearing aids. R7's Care Plan dated 06/07/23 documented R7 had a communication problem related to having difficulty understanding or making his needs known, related to a hearing deficit. The plan did not address R7's hearing aids.R7s Physician's Orders documented an order that directed the Certified Medication Aide (CMA) to ensure that the resident had a leg bag on, his hair was combed, his face washed, and shaved. The order directed to ensure R7 had clean clothes and a hearing aid when going to the Program of All-Inclusive Care for the Elderly (PACE) Monday through Friday by 08:30 AM, date ordered 04/10/25. R7s Physician's Orders documented an order to place the hearing aid on the charger in the medication room at bedtime, date ordered 04/23/25R7's Progress Note dated 01/23/25 at 09:07 AM documented that his right hearing aid was identified as missing when staff assisted R7 in getting ready for PACE services.R7's Progress Note dated 04/29/25 at 03:28 AM documented that the staff were unable to find the hearing aids to place on the charger in the medication room. R7's Progress Note dated 05/03/25 at 09:56 PM documented R7 did not have hearing aids on, and the hearing aids could not be located. R7's Progress Note dated 06/23/25 at 07:45 PM documented that hearing aids were not with R7 when he returned from PACE. During an observation on 06/29/25 at 01:55 PM, R7 had no hearing aids in his ears. R7 sat in the television lounge with the television on. R7 had difficulty hearing when he was asked questions. During an observation on 06/30/25 at 03:40 PM, R7 returned from the PACE program and was seated in his wheelchair at the church service activity. R7 had no hearing aids in his ears. Certified Nurse Aide (CNA) JJ found the hearing aids in a bag attached to the back of R7's wheelchair. During an observation on 07/01/25 at 08:25 AM, R7 sat in the television lounge in a recliner with no hearing aids noted in his ears. R7 reported he had no hearing aids when asked. On 06/30/25 at 11:21 AM, Activity Staff Z reported that R7 required bilateral hearing aids, and the nursing staff would apply the hearing aids. On 07/01/25 at 08:36 AM, CNA O reported she had to wait for the Certified Medication Aide to give her R7's hearing aids out of the locked medication cart. CNA O reported R7 had been up in his recliner for a couple of hours now and had his breakfast without his hearing aids applied. On 07/01/25 at 09:48 AM, CMA R reported she had not placed R7's hearing aids in his ears that morning and reported that the nurse had applied them as the hearing aids were no longer locked up in the medication room. On 07/01/25 at 09:55 AM, Licensed Nurse (LN) G reported she applied R7's hearing aids before he transferred to PACE that morning. LN G reported that R7's hearing aids could not be located at times, but eventually, staff would find them.On 07/01/25 at 11:52 AM, Administrative Nurse F expected staff to apply and remove the resident's hearing aids daily. The facility's policy Care and Use of Hearing Aids, dated 11/08/24, documented it is the practice of this facility to assist residents in using their hearing aids and to provide care to the hearing aids to ensure they are clean and protected from loss or breakage when not in use.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 44 residents; the sample included 12 residents. Based on observation, interview, and record review, the facility failed to develop and implement a system to ensure the presence of at least one staff certified in cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) during transportation provided by the facility for residents who desired a Full Code status (full resuscitative measures). This deficient practice placed the residents at risk for decreased quality of care and inadequate resuscitative measures.Findings included:- Review of Certified Nurse Aide (CNA) /Transportation Aide's O's health care credentials revealed she lacked CPR certification. Review of the facility's Code Status Listing dated [DATE], revealed 24 of the 44 residents identified as Full Code (requesting to receive CPR in the event their heart stopped and/or breathing stopped). Review of the Transportation Schedule/Log, dated [DATE] through [DATE], revealed that CNA O transported 17 Full Code residents for 52 separate appointments during that time frame. The resident transported by the facility for offsite appointments without available CPR-certified staff included Resident (R)12, R18, R29, R32, and R36. On [DATE] at 12:38 PM, Administrative Nurse D confirmed the above findings. She reported that the facility should ensure a CPR-certified staff member is available when transporting residents to appointments. She agreed that the lack of CPR-certified staff when providing transportation placed the residents at risk for decreased quality of care and inadequate resuscitative measures. The 06/2017 facility policy Medical Emergency Response documentation included that current certified staff must maintain CPR-Certification for Healthcare Providers through a CPR provider whose training includes hands-on skills practice and in-person assessment and demonstration of skills. CPR-certified staff are available at all times.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 44 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to provide adequate supervision to cognitively impaired, independently mobile Resident (R)30, identified as a high risk for elopement (when a cognitively impaired resident leaves the facility or safe area without staff knowledge or supervision). This placed the resident at risk for injuries, accidents, and further elopements. Findings included:- Review of the Electronic Health Record (EHR) documented R30 had diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), and mood disorder. R30 was admitted to the facility on [DATE].R30's 09/15/24 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) of eight, which indicated moderately impaired cognition. The MDS documented R30 required maximal assistance for bathing, transfers, dressing, and toileting. The MDS documented R30 required moderate assistance with oral care, personal hygiene, and bed mobility. The MDS documented R30 was independent with eating and wheelchair mobility. The MDS documented R30 had wandering behaviors daily and placed the resident at significant risk of getting to a potentially dangerous place, like outside the facility. R30's 09/18/24 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R30 had impaired cognitive function/dementia or impaired thought processes related to his dementia. R30 would get agitated when he could not remember what to do or how to do it. R30 would wander looking for different places. R30's 09/18/24 Behavioral Symptoms CAA documented R30 was an elopement risk and wandered aimlessly. R30's information and photo were placed in the elopement book. Staff are aware R30 was a risk for elopement, and his anxiety could cause him to wander. R30's 04/30/25 Quarterly MDS documented a BIMS score of eight, which indicated moderately impaired cognition; no behaviors were noted. The MDS documented R30 was dependent on staff assistance for toileting and required maximal assistance with showers and moderate assistance with lower dressing. The MDS documented R30 was independent with eating and wheelchair mobility.R30's Care Plan dated 09/17/24, documented R30 was at risk for elopement related to cognitive status, mobility status, and assessment indicating a high risk potential for wandering/elopement. The plan directed staff to provide the following interventions:Encourage independence while in the building, but ensure supervision while outside.Encourage participation in positive, meaningful activity programs or choices. Engage R30 in active conversation as a form of redirection.In the event of an elopement, follow search and reporting protocols.Keep the routine consistent to alleviate confusion.Observe for signs/symptoms of acute illness, which may enhance confusion.Provide picture/identification and description of R30 in the elopement book.Redirect when wandering around doors/exits.Visualize the resident's whereabouts frequently.R30's Wandering/Elopement Risk Scale dated 09/10/24 and 12/20/24 documented a score of 10.0, which indicated the resident was at risk to wander. R30's Progress Note on 12/22/24 at 01:00 PM, documented upon coming out of the third dining room bathroom, an unknown Licensed Nurse (LN) was notified by an unknown Certified Nurse Aide (CNA) that a family member alerted staff that R30 exited the building through the north side Emporia Lane hallway exit. The note recorded both the LN and CNA ran to the door. The LN entered the door code and ran outside to find R30 in his wheelchair on a street near the facility. The note recorded the LN asked R30 what he was doing, to which he said he was leaving the [expletive] place. The note documented staff found and safely returned R30 into the facility, and the elopement procedure was initiated. Staff assessed R30 for pain, which he denied, and injuries; none were noted.R30's Risk Management Report dated 12/22/24 at 01:00 PM documented the above note and that R30 was oriented to person but confused with impaired memory; he was an active seeker and wanderer. Maintenance Supervisor U's Witness Statement dated 12/22/24 documented he showed up to the facility at 01:35 PM to check the function of the exit door on Emporia Hall. The door alarm worked with no concerns. The housekeeper's Witness Statement dated 12/22/24 documented that she was on Jayhawk hallway and a family member came to tell her a resident had left. The family member thought the housekeeper did not understand and went to get other staff members. The housekeeper entered the code in the door, and another lady went and got R30.The Logbook Report for Doors, Locks, and Alarms for exit doors documented the doors were checked weekly, and were last checked on 12/21/24, and were functioning. During an observation on 06/30/25 at 09:40 AM, R30 was noted to be able to self-propel in his wheelchair in the hallway.On 06/29/25 at 01:09 PM, R30's representative reported that R30 was found outside the facility last year and reported she was told he did not

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	175280	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Hills Care and Rehabilitation Center	1620 Wheeler Street Emporia, KS 66801

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	The facility reported a census of 44 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to administer scheduled pain medication and take action to manage severe pain for Resident (R)32. Additionally, the facility failed to re-order the scheduled pain medication and notify the provider when the pain medication was not available. As a result of the deficient practice, R32 experienced severe pain with ineffective pain relief for two days and had physical symptoms of abrupt withdrawal, including nausea and vomiting, related to the facility not administering the scheduled, physician ordered pain medication. This also placed R32 at risk for discomfort and further decline in her overall well-being.Findings included: - A review of the Electronic Health Record (EHR), documented R32 had diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right hip, chronic pain, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R32's 02/01/25 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R32 required supervision for bathing and was independent in all activities of daily living (ADL). The MDS documented R32 received no routine pain medications; R32 did not receive as-needed pain medications or non-medicated pain intervention during the observation period. The MDS noted R1 had reported occasional pain with a pain score of three (pain scale with zero indicating no pain and 10 the worst pain imaginable) during the interview. R32's Pain Care Area Assessment (CAA) dated 02/18/25, documented R32 was at risk for alterations in comfort related to cervical (neck/spine) disc disorder. R32 would maintain current level of function and have minimal risks. R32's 05/05/25 Quarterly MDS documented a BIMS score of 13, which indicated intact cognition. The MDS documented R32 required moderate assistance for bathing and was independent for all other ADLs. The MDS documented R32 received routine pain medications, received non-medicated pain intervention, and did not receive as-needed pain medications during the observation period. The MDS noted R32 reported almost constant pain with a pain score of nine out of 10 during the interview. R32's Care Plan dated 04/19/24 directed staff to notify the physician if interventions were unsuccessful or if the current complaint of pain was a significant change from past experiences. The plan instructed staff to monitor and record pain characteristics every shift and as needed for quality and severity using a pain scale of one to ten, location, onset, duration, aggravating factors, and relieving factors. The plan instructed staff to administer analgesics per orders. The plan, dated 03/28/25, instructed staff R32's acceptable pain level was seven. The plan instructed staff to provide non-pharmacological pain interventions such as heat, ice, coloring, watching television, and plants. The plan, dated 05/08/25, instructed staff to identify, record, and treat existing conditions that may increase pain and or discomfort. R32's Physician Orders documented the following orders:Pain monitoring; (able to communicate) Are you free of pain or hurting? If no, indicate response through chart code Y for yes and N for no. Address new or changes in pain, complete pain evaluation in user define assessment every shift for pain, dated 02/11/25.Pregabalin capsule (medication used to treat nerve pain) 150 milligrams (mg), give one capsule by mouth, three times a day for right hip pain, dated 04/26/25. Acetaminophen (over-the-counter pain medication) oral tablet 325 mg, give two tablets by mouth, every four hours as needed for general discomfort, dated 06/28/25. R32's June 2025 Medication Administration Record (MAR) documented the pregabalin 150 mg capsule was not administered on the following dates:06/28/25 07:00 PM through 10:00 PM.06/29/25 07:00 AM through 10:00 AM, 11:00 AM through 02:00 PM, and 07:00 PM through 10:00 PM. 06/30/25 between 07:00AM thru 10:00AM. R32's June 2025 MAR documented R32 received as needed acetaminophen 325 mg tablet two by mouth on 06/28/25 at 05:51 PM for a pain score of seven that was effective. R32's MAR lacked any documentation that R32 received any as-needed acetaminophen for pain on 06/29/25 and 06/30/25.R32's June MAR from 06/28/25 through 06/30/25 documented Y indicating the resident was free from pain each shift. R32's X-ray Report dated 02/22/25 documented severe osteoarthritis of the right hip marked by severe narrowing of the weight-bearing aspect of the hip joint, subarticular sclerosis (a hardening or increased density of the bone located just below the cartilage in the hip joint) and marginal osteophytosis (also known as bone spurs or osteophytes, refers to the formation of abnormal bony growths around the hip joint).R32's Progress Note dated 02/28/2025 at 12:08 PM documented the resident had an orthopedic appointment that day for right hip pain. The note documented the following physician communication: The X-rays of the right hip showed advanced arthritis and R32 would need a revision

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 44 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interview, and record review, the facility failed to notify the physician for blood sugars outside of the physician-ordered parameters for Resident (R) R29. The deficient practice placed the affected resident at risk for complications related to hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar)Findings included:- R29's Physician Orders dated 06/01/25 revealed the following diagnosis: type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R29's Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS noted R29 dependent upon staff for all activities of daily living (ADLs). The MDS did not indicate that injections or insulin were administered.R29's Quarterly MDS dated [DATE] indicated a BIMS score of zero, indicating severely impaired cognition. The MDS noted R29 received seven days of injections and seven days of insulin (a hormone that lowers the level of glucose in the blood) during the observation period.R29's Care Plan, revised on 02/22/25, indicated R29 received diabetes medication as ordered by the physician, and fasting blood sugars as ordered four times a day. The plan directed staff to report blood sugars if less than 60 milligrams per deciliter (mg/dl) and greater than 400 mg/dl. R29's Physician Orders documented a finger stick blood glucose four times a day; notify the physician if the blood sugar is less than 60 mg/dl or greater than 400 mg/dl R29's Electronic Medical Record (EMR) under the Vitals tab, reviewed from 04/18/25 to 06/30/25, documented two blood sugars over the 400 mg/dl parameter. On 05/11/25 at 05:02 PM, R29's blood sugar was 435 mg/dl. On 05/13/25 at 10:40 AM, R29's blood sugar was 499 mg/dl.R29's Progress Notes dated 05/11/25 at 05:02 PM lacked evidence of notification to the physician for blood sugars out of the parameters.R29's Progress Note dated 05/13/25 at 10:40 AM lacked evidence of notification to the physician for blood sugars outside the parameters.On 07/01/25 at 11:00 AM, Licensed Nurse (LN) G stated that the nurses should notify the physician of blood sugars when the level is above the ordered parameters to obtain an order for an additional dose of insulin.On 07/01/25 at 11:10 AM, Administrative Nurse D stated the nursing staff should reach out to the physician for additional insulin orders when blood sugars are above the parameters. The facility did not provide a policy for unnecessary medications.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility reported a census of 44 residents. Based on record review and interviews, the facility failed to submit accurate staffing information through Payroll Based Journaling (PBJ - Staffing Data Report), when the facility failed to submit accurate weekend staffing coverage hours.Findings included:- Review of the PBJ Quarterly Staffing Data Report documented that the facility had excessively low weekend staffing in Fiscal Year (FY) 2024 Quarter (Q) 3, FY 2024 Q4, FY 2025 Q1, and FY 2025 Q2.Review of the Nursing Schedule and nursing hours for weekend staffing during the above-noted quarters revealed staffing was adequate and consistent with the weekday (Monday through Friday) staffing patterns.On 07/01/25 at 12:38 PM, Administrative Staff A and Administrative Nurse D reviewed the PBJ reports, the nursing schedule, and daily staff postings for the weekends of the above-noted quarters and concurred that the PBJ Data Reports were inaccurate. They stated the facility's administrative nurses often filled in on the weekends to provide direct care. They confirmed those hours were not reflected in the PBJ data reports. Administrative Staff A stated that the facility's corporate office submitted the PBJ data and did not accurately reflect the direct care nursing time provided to the residents of the facility.The facility did not provide a policy to address reporting accurate PBJ Data.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported a census of 44 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care for Resident (R) 7. Additionally, the facility failed to provide adequate incontinence care (the management and support provided to individuals who experience involuntary loss of urine) for R40 and R34 when staff failed to complete proper hand hygiene and cleansing of the peri-area. The facility failed to store respiratory equipment in a sanitary manner for R32 and R20. The facility failed to provide personal protective equipment (PPE- gowns, face shields, /eyeglasses/goggles, and gloves) for the laundry staff to utilize when sorting soiled linens. These deficient practices had the potential to spread infections to the residents in the facility.Findings included:- Observation on 06/29/25 at 10:55 AM, R32's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) was intact, with clear liquid noted in the medication chamber, and the intact nebulizer system was in a plastic bag. R32 reported she received her breathing treatment last night and had not seen the staff rinse the nebulizer equipment.Observation on 06/29/25 at 11:00 AM, Certified Nurse Aide (CNA) P and CNA Q provided peri-care to R40. Neither CNA changed their gloves in between the dirty and the clean during peri-care provided. CNA P reported she did not know to change gloves and perform hand hygiene between the clean and the dirty actions of the task.Observation on 06/29/25 at 12:11 PM CNA P moved back and forth between residents, standing while assisting the three residents to eat lunch. CNA P wiped off the residents' faces with their neck napkin and picked up another resident's fork without any hand hygiene being completed during the entire time CNA P assisted the residents. CNA P handled her cell phone several times when assisting the three residents to eat.During an observation on 06/30/25 at 08:30 AM, R20's nebulizer was attached to the machine, and the medication chamber had a clear liquid in the chamber. Licensed Nurse (LN) H prepared to administer R20's nebulizer medication. LN H dumped the clear liquid out of the chamber and added the new medication to the chamber to administer the treatment. LN H reported nurses would rinse the nebulizer out after each use, place the equipment on a paper towel to air dry, and then place the equipment into the storage bag.During an observation on 06/30/25 at 08:37 AM, CNA KK and CNA O provided peri-care to R34. CNA O applied double gloves and removed the first pair after she cleansed the peri-area and then applied the barrier cream. CNA O commented as she removed her gloves that her gloves were now clean to the other aide.During an observation on 06/30/25 at 03:51 PM, CNA JJ applied gloves without performing hand hygiene. CNA JJ did not don a gown. CNA JJ placed two unopened alcohol prep packets on the floor, grabbed an alcohol prep packet off the bathroom floor, opened it up, and placed the alcohol prep pad on her pant leg. CNA JJ emptied the leg bag, and the drain release hit the inside of the graduate several times. CNA JJ used the alcohol pad that was on her pant leg and wiped the drain release. CNA JJ used the dirty gloved hand on the handle of the faucet to turn it on and off, then took off her gloves, picked up the other prep pad off the floor, and propelled the resident back to the lounge in his wheelchair. CNA JJ then performed hand hygiene.During an observation on 07/01/25 at 12:40 PM, no PPE was noted in the soiled part of the laundry room. Laundry Staff W reported that she never wore a gown or goggles in the soiled laundry area when she sorted laundry; she reported she wore just disposable gloves.On 06/29/25 at 12:52 PM, CNA P reported that normally there were more staff to assist residents with meals, and she had to assist all the residents.On 06/29/25 at 01:25 PM, LN G reported that the staff who assisted the residents in the dining room should sanitize their hands between residents. LN G said staff were not to handle their personal cell phones during care.During an interview with CNA O and CNA KK on 06/30/25 at 08:50 AM, CNA O reported that she wore double gloves as it was easier to do that since it was a messy job to complete. CNA KK reported that she would normally change her gloves when providing care, but she would not always wash her hands in between glove changes.During an interview on 06/30/25 at 04:00 PM, CNA JJ reported she should have washed her hands prior to the procedure, and she should have worn a gown. She reported she should have placed the prep pads on a barrier, and she should not have touched the leg bag drain to the inside of the graduate, and she should have washed her hands before she moved the resident back to the lounge.During an interview on 06/30/25 at 04:04 PM, LN H reported the staff should wear PPE, including a gown, when performing care when emptying the catheter bag. LN H reported that handwashing