STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175324	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Dorado Care and Rehab	900 Country Club Lane El Dorado, KS 67042

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 37 residents. The sample included four residents sampled for quality of care. Based on observation, interview, and record review, the facility failed to ensure that three Residents(R)2, R 3, and R 4, received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and/or the residents' choices, related to skin treatments for ostomies (an artificial opening in an organ created during an operation as ordered by the physician. Findings included: - Review of Resident (R)2's, undated Physician Orders, documentation revealed diagnoses which included quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), urinary tract infection, and retention of urine. The Annual Minimum Data Set, dated dated [DATE], documented the resident's short term and long-term memory intact. He had an indwelling catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Urinary Incontinence Care Area Assessment (CAA), dated 07/26/23, triggered secondary to use of a supra pubic catheter (urinary bladder catheter inserted through the abdomen into bladder). Risk factors included recurrent urinary tract infections (UTI is an infection in any part of the urinary system) and injury from use of a catheter. The care plan would be initiated to maintain catheter per facility policy and physician orders and decrease the risk for recurrent UTIs. The Care Plan dated 02/25/24, directed staff the resident had an indwelling suprapubic catheter related to urinary retention and staff were to provide treatment to the supra pubic site as per physician orders. The Physician Orders, documentation included cleanse the suprapubic catheter site with Normal Saline Solution (NSS) and apply a dry dressing every night shift for infection control and hygiene, and as needed for soilage and hygiene, ordered 08/26/2022. On 03/14/24 at 10:14 AM, the resident was in bed. The supra pubic site had a dressing in place, dated 03/12/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/24 at 09:38 AM, Licensed Nurse (LN) G reported the night nurse were to change the dressings according to the physician's orders and as directed by the care plan for supra pubic catheters and feeding tubes. On 3/14/24 at 11:05 AM, LN H reported the night shift nurse should change R2's dressing as ordered by the physician, and if it is soiled or wet to prevent infection and skin breakdown. She confirmed the resident's supra pubic dressing dated 03/12/24 and should have been changed on 03/13/24, LN H verified the nurse for 03/13/24 as an agency nurse and did not change the dressing. She stated the night shift dressings were not done on occasion. LN H stated she reported her concern with dressings on night shift not being done as physicians ordered to the previous Administrative Nurse B and was not aware of the follow-up. She confirmed she had not reported the concern to the most recent Administrative Nurse A. She stated it was not uncommon for the resident's dressing to not be completed as ordered. On 03/14/24 at 02:30 PM, Administrative Nurse A confirmed the night nurse was responsible for changing the resident's supra pubic dressing nightly. She confirmed the night nurse on 03/13/24 should have changed the dressing as ordered by the physician to prevent infection and monitor the skin for breakdown. The facility lacked a policy to address changing dressings for supra pubic catheter insertion sites to prevent infections and maintain skin integrity. The facility failed to ensure the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and/or the residents' choices, related to skin treatments for this resident that required supra pubic catheter dressing changes. - Review of Resident (R)3's diagnoses included chronic kidney disease, and retention of urine. The Annual Minimum Data Set, dated dated [DATE], documented the resident's Brief Interview for Mental Status, (BIMS) score of 15, indicating R3 was cognitively intact. He had an indwelling catheter (tube placed in the bladder to collect urine). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 01/03/24, triggered secondary to use of supra pubic catheter (urinary bladder catheter inserted through the abdomen into bladder). Risk factors included recurrent urinary tract infections (UTI) and injury from use of a catheter. The care plan will be initiated to maintain catheter per facility policy and physician orders and decrease risk for recurrent UTIs. The Care Plan dated 03/10/24, directed staff the resident had an indwelling Suprapubic Catheter related to urinary retention to provide treatment to supra pubic site as per physician orders. The Physician Orders, documentation included to cleanse the suprapubic catheter site with Normal Saline Solution (NSS) and apply a dry dressing every night shift, for infection control and hygiene, and as needed for soilage and hygiene, ordered 12/08/2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/24 at 09:38 AM, Licensed Nurse (LN) G reported the night nurse should change the dressings according to the physician's orders, and as directed by the care plan for supra pubic catheters and feeding tubes. On 3/14/24 at 11:05 AM, LN H reported the night shift nurse should change R2's dressing as ordered by the physician, and if it is soiled or wet to prevent infection and skin breakdown. She confirmed the resident's supra pubic dressing dated 03/12/24 and should have been changed on 03/13/24, LN H verified the nurse for 03/13/24 as an agency nurse and did not change the dressing. She stated the night shift dressings were not done on occasion. LN H stated she reported her concern with dressings on night shift not being done as physicians ordered to the previous Administrative Nurse B and was not aware of the follow-up. She confirmed she had not reported the concern to the most recent Administrative Nurse A. She stated it was not uncommon for the resident's dressing to not be completed as ordered. On 3/14/24 at 11:22 AM, LN H confirmed R3's supra pubic dressing dated 3/12/24, with LN H's initials. On 03/14/24 at 02:30 PM, Administrative Nurse A confirmed the night nurse was responsible for changing the resident's supra pubic dressing nightly. She confirmed the night nurse on 03/13/24 should have changed the dressing as ordered by the physician to prevent infection and monitor the skin for breakdown. The facility lacked a policy to address changing dressings for supra pubic catheter insertion sites to prevent infections, maintain skin integrity. The facility failed to ensure this resident that required supra pubic dressing changes, received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and/or the residents' choices, related to skin treatments for ostomies. - Review of Resident (R)4's, undated Physician Orders, documentation revealed diagnoses which included quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord) urinary tract infection, retention of urine, aphasia (loss of the ability to swallow) following cerebral infarction (stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). The Admission Minimum Data Set, dated dated [DATE], documented the resident's Brief Interview for Mental Status, (BIMS) score of five, indicating severe cognitive impairment. R4 required a feeding tube-nasogastric or abdominal percutaneous gastrostomy tube (peg). The Feeding Tube Care Area Assessment (CAA) dated 04/19/23, revealed R4 required the use of a feeding tube via peg-tube for maintenance of nutritional/hydration status. Contributing factors included dysphagia (swallowing difficulty), and recent acute medical condition and decline. The Care Plan dated 01/22/24, directed staff the resident required tube feeding, and staff were to administer medications as ordered. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Orders, documentation included staff was to wash R4's gastrostomy tube insertion site with soap and water, apply a dressing every night, and as needed, every night shift, ordered 06/16/2023. On 03/14/24 at 11:36 AM, R4 was in his bed with the head of the bed elevated. Licensed Nurse (LN) H entered the room and examined the resident's gastrostomy tube insertion site. She confirmed the dressing in place had been dated 03/12/24, two days prior. LN H stated his gastrostomy tube dressing should be changed daily. to prevent skin breakdown from leaking acidic stomach content. LN H reported the night shift nurse should change R4's dressing as ordered by the physician, and if it is soiled or wet to prevent infection and skin breakdown. She stated the night shift dressings were not done on occasion. She stated it was not uncommon for the resident's dressing to not be completed as ordered. On 03/14/24 at 09:38 AM, Licensed Nurse (LN) G reported the night nurse was to change the dressings according to the physician's orders and as directed by the care plan for feeding tubes. On 03/14/24 at 02:30 PM, Administrative Nurse A confirmed the night nurse was responsible for changing the resident's gastrostomy tube insertion site dressing nightly. She confirmed the night nurse on 03/13/24 should have changed the dressing as ordered by the physician to prevent infection and monitor the skin for breakdown. The facility lacked a policy to address changing dressings for gastrostomy insertion sites to prevent infections and maintain skin integrity. The facility failed to ensure the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and/or the residents' choices, related to skin treatments for this resident that required gastrostomy insertion site dressing changes.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 37 residents. The sample included four residents sampled for procedures of following physician orders. Based on observation, interview, and record review, the facility failed to ensure three Residents(R)2, R 3, and R 4, received treatment and care in accordance with physician's orders related to skin treatments for ostomies (an artificial opening in an organ created during an operation as ordered by the physician). Findings included: - Review of Resident (R)2's, undated Physician Orders, documentation revealed diagnoses which included quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), urinary tract infection, and retention of urine. The Annual Minimum Data Set, dated dated [DATE], documented the resident's short term and long-term memory intact. He had an indwelling catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Urinary Incontinence Care Area Assessment (CAA), dated 07/26/23, triggered secondary to use of a supra pubic catheter (urinary bladder catheter inserted through the abdomen into bladder). Risk factors included recurrent urinary tract infections (UTI is an infection in any part of the urinary system) and injury from use of a catheter. The care plan would be initiated to maintain catheter per facility policy and physician orders and decrease the risk for recurrent UTIs. The Care Plan dated 02/25/24, directed staff the resident had an indwelling suprapubic catheter related to urinary retention and staff were to provide treatment to the supra pubic site as per physician orders. The Physician Orders, documentation included cleanse the suprapubic catheter site with Normal Saline Solution (NSS) and apply a dry dressing every night shift for infection control and hygiene, and as needed for soilage and hygiene, ordered 08/26/2022. On 03/14/24 at 10:14 AM, the resident was in bed. The supra pubic site had a dressing in place, dated 03/12/24. On 03/14/24 at 09:38 AM, Licensed Nurse (LN) G reported the night nurse was to change the dressings according to the physician's orders and as directed by the care plan for supra pubic catheters and feeding tubes. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 11:05 AM, LN H reported the night shift nurse should change R2's dressing as ordered by the physician, and if it is soiled or wet to prevent infection and skin breakdown. She confirmed the resident's supra pubic dressing dated 03/12/24 and should have been changed on 03/13/24, as ordered. LN H verified the nurse for 03/13/24 as an agency nurse and did not change the dressing as ordered by the physician. She stated the night shift dressings were not done on occasion. LN H stated she reported her concern with dressings on night shift not being done as physicians ordered to the previous Administrative Nurse B and was not aware of the follow-up. She confirmed she had not reported the concern to the most recent Administrative Nurse A. She stated it was not uncommon for the resident's dressing to not be completed as ordered by the physician. On 03/14/24 at 02:30 PM, Administrative Nurse A confirmed the night nurse was responsible for changing the resident's supra pubic dressing nightly in accordance with the physician's orders. She confirmed the night nurse on 03/13/24 should have changed the dressing as ordered by the physician to prevent infection and monitor the skin for breakdown. The facility lacked a policy to address following physician orders related to changing dressings for supra pubic catheter insertion sites to prevent infections and maintain skin integrity. The facility failed to ensure the resident received treatment and care in accordance with the physician's orders, related to the care and treatment of his supra pubic catheter dressing changes. - Review of Resident (R)3's diagnoses included chronic kidney disease, and retention of urine. The Annual Minimum Data Set, dated dated [DATE], documented the resident's Brief Interview for Mental Status, (BIMS) score of 15, indicating R3 was cognitively intact. He had an indwelling catheter (tube placed in the bladder to collect urine). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 01/03/24, triggered secondary to use of supra pubic catheter (urinary bladder catheter inserted through the abdomen into bladder). Risk factors included recurrent urinary tract infections (UTI) and injury from use of a catheter. The care plan will be initiated to maintain catheter per facility policy and physician orders and decrease risk for recurrent UTIs. The Care Plan dated 03/10/24, directed staff the resident had an indwelling Suprapubic Catheter related to urinary retention to provide treatment to supra pubic site as per physician orders. The Physician Orders, documentation included to cleanse the suprapubic catheter site with Normal Saline Solution (NSS) and apply a dry dressing every night shift, for infection control and hygiene, and as needed for soilage and hygiene, ordered 12/08/2022. On 03/14/24 at 10:14 AM, the resident was in bed. The supra pubic site had a dressing in place, dated 03/12/24. On 03/14/24 at 09:38 AM, Licensed Nurse (LN) G reported the night nurse were to change the dressings according to the physician's orders and as directed by the care plan for supra pubic catheters and feeding tubes. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 11:05 AM, LN H reported the night shift nurse should change R3's dressing as ordered by the physician, and if it is soiled or wet to prevent infection and skin breakdown. She confirmed the resident's supra pubic dressing dated 03/12/24 and should have been changed on 03/13/24, LN H verified the nurse for 03/13/24 as an agency nurse and did not change the dressing as ordered by the physician. She stated the night shift dressings were not done on occasion. LN H stated she reported her concern with dressings on night shift not being done as physicians ordered to the previous Administrative Nurse B and was not aware of the follow-up. She confirmed she had not reported the concern to the most recent Administrative Nurse A. She stated it was not uncommon for the resident's dressing to not be completed as ordered by the physician. On 03/14/24 at 02:30 PM, Administrative Nurse A confirmed the night nurse was responsible for changing the resident's supra pubic dressing nightly in accordance with the physician's orders. She confirmed the night nurse on 03/13/24 should have changed the dressing as ordered by the physician to prevent infection and monitor the skin for breakdown. The facility lacked a policy to address following physician orders related to changing dressings for supra pubic catheter insertion sites to prevent infections and maintain skin integrity. The facility failed to ensure the resident received treatment and care in accordance with physician's orders, related to skin treatments for this resident that had physician orders for the care and treatment of his supra pubic catheter dressing changes. - Review of Resident (R)4's, undated Physician Orders, documentation revealed diagnoses which included quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord) urinary tract infection, retention of urine, aphasia (loss of the ability to swallow) following cerebral infarction (stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). The Admission Minimum Data Set, dated dated [DATE], documented the resident's Brief Interview for Mental Status, (BIMS) score of five, indicating severe cognitive impairment. R4 required a feeding tube-nasogastric or abdominal percutaneous gastrostomy tube (peg). The Feeding Tube Care Area Assessment (CAA) dated 04/19/23, revealed R4 required the use of a feeding tube via peg-tube for maintenance of nutritional/hydration status. Contributing factors included dysphagia (swallowing difficulty), and recent acute medical condition and decline. The Care Plan dated 01/22/24, directed staff the resident required tube feeding, and staff were to administer medications as ordered. The Physician Orders, documentation included staff was to wash R4's gastrostomy tube insertion site with soap and water, apply a dressing every night, and as needed, every night shift, ordered 06/16/2023. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/24 at 11:36 AM, R4 was in his bed with the head of the bed elevated. Licensed Nurse (LN) H entered the room and examined the resident's gastrostomy tube insertion site. She confirmed the dressing in place had been dated 03/12/24, two days prior. LN H stated his gastrostomy tube dressing should be changed daily to prevent skin breakdown from leaking acidic stomach content. LN H reported the night shift nurse should change R4's dressing as ordered by the physician, and if it is soiled or wet to prevent infection and skin breakdown. She stated the night shift dressings were not done on occasion. She stated it was not uncommon for the resident's dressing to not be completed as ordered. On 03/14/24 at 09:38 AM, Licensed Nurse (LN) G reported the night nurse was to change the dressings according to the physician's orders and as directed by the care plan for feeding tubes. On 03/14/24 at 02:30 PM, Administrative Nurse A confirmed the night nurse was responsible for changing the resident's gastrostomy tube insertion site dressing nightly according to the physician's orders. She confirmed the night nurse on 03/13/24 should have changed the dressing as ordered by the physician to prevent infection and monitor the skin for breakdown. The facility lacked a policy to address following physician orders to address changing dressings according to physician's orders for gastrostomy insertion sites to prevent infections and maintain skin integrity. The facility failed to ensure the resident received treatment and care in accordance with physician orders related to skin treatments for this resident that required gastrostomy insertion site dressing changes.