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	10/02/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 34 residents with 14 residents selected for review, which included one resident reviewed for self-determination. Based on observation, interview, and record review, the facility failed to ensure one Resident (R)5, received appropriate preparations for his scheduled surgery. Findings included: - Review of Resident (R)5's diagnoses included paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk) due to demyelinating (a disease of the spinal cord, nerves and brain causing paralysis and weakness) disease of the central nervous system, and cutaneous (in the skin) abscess (cavity containing pus and surrounded by inflamed tissue) of the abdominal wall. The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. The resident had impairment in both lower extremities and no impairment in upper extremities. The Activities of Daily Living Functional (ADL) /Rehabilitation Care Area Assessment (CAA), dated 03/20/24, assessed the resident was dependent on staff for ADLs due to paraplegia, weakness, infections, and risk factors included unresolved skin issues. The Return to Community Referral CAA dated 03/20/24, assessed the resident wanted to return home, with barriers related to paralysis, wounds and inability to care for self. The pressure ulcers Care Plan reviewed 09/18/24, revealed cares related to the resident's old PEG (percutaneous endoscopic gastrostomy: a feeding tube that is inserted through the abdominal wall directly into the stomach) tube site had MASD (moisture associated skin damage) and staff were to cleanse the area with normal saline and apply skin prep and zinc oxide paste. A Physician's Order dated 07/20/24, instructed staff to administer ferrous sulfate (an iron supplement), 325 milligrams (mg), daily. A Physician's Order dated 08/28/24, instructed staff to administer Eliquis (a medication used to prevent blood clots), 2.5 mg, twice a day. (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: 175324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note dated 09/25/24, documented the lack of preoperative orders, realized by nursing staff when the resident refused to take his blood thinner for the planned surgery. Observation on 09/30/24 at 02:35 PM, revealed the resident had a gauze pad covering the PEG tube site, with dark brown drainage on it. The resident stated the drainage was gastric acid and caused the skin damage to the surrounding skin. Interview, on 09/30/24 at 02:35 PM, R5 reported he desired to return home but had to overcome many obstacles. He stated he was self-sufficient in the past with paraplegia but now had multiple medical issues that needed treatment but was determined to overcome the obstacles and return home. He stated his PEG tube had been surgically closed in August 2024, but failed, and he was scheduled for another attempt at closure in September 2024, but staff did not hold his blood thinner and iron, and surgery had to be canceled. He stated the surgery had to be rescheduled for 10/23/24, which he felt further delayed his plans to return home. Interview, on 10/02/24 at 08:45 AM with Certified Nurse Aide (CNA) N, revealed she was notified of the need for transportation for the resident on 09/26/24 , for surgery and knew the time of arrival. She thought the nursing staff had the orders for the surgery. Interview, on 10/02/24 at 02:01 PM with Administrative Nurse E, revealed the resident set up the surgery for closure of the PEG tube site on 09/26/24 and notified nursing staff that the physician's office would send the preoperative orders to the facility. Administrative Nurse E stated nursing staff did not receive the orders and did not follow up with the physician's office for preoperative instructions. Interview, on 10/02/24 at 02:30 PM with Administrative Nurse D, confirmed the nursing staff did not prepare the resident for surgery, by not ensuring preoperative orders received, which resulted in the surgery delayed and required to be rescheduled for 10/23/24. The facility lacked a policy staff to ensure components of planned operative procedures were in place. The facility failed to ensure preoperative orders were obtained for this resident's planned procedure which resulted in the rescheduling of the procedure for 27 days, which further delayed the resident's progress toward his goal of returning to his home.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36881

The facility reported a census of 34 residents. The sample of 14 residents included three residents reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to provide two Residents (R), R27 and R 3, who required respiratory care, including tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) care and tracheal suctioning, provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences related to the storage of suctioning cannulas/tubing to when not in use to prevent infection and cross contamination to prevent infection.

Findings included:

- Review of Resident (R)27's Physician Orders, dated 08/07/24 revealed the following diagnoses that included spastic quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), with tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted), chronic respiratory failure with hypoxia (inadequate supply of oxygen), abnormalities of breathing, disorders of lungs, pneumonia (inflammation of the lungs), due to pseudomonas aeruginosa mallei psuedomallei (type of microorganisms/bacteria related to infection) , and developmental disorder of speech and language.

The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognition. R27 rarely/never understood. She received special care and treatment which included oxygen, suctioning, and tracheostomy. R 27 received antibiotic medication.

The Care Plan dated 07/24/24, directed staff the resident with a tracheostomy related to impaired breathing mechanics. Staff were to monitor the resident for potential for respiratory infection. The suctioning tubing should be put away properly to prevent infection/ related to contamination.

The Physician Orders, dated 08/07/24, documentation included:

1. When tracheostomy suctioning, the suctioning tubing is to be put away properly to prevent infection/contamination. Suctioning every two hours related to chronic respiratory failure with hypoxia.

2. Ciprofloxacin HCl Tablet (antibiotic used to treat infection), 500 milligrams (MG), give 1 tablet via gastrostomy tube every 12 hours for pneumonia, for seven days, ordered 09/25/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 08:29 AM, R27 was in bed with the head of bed elevated and the tube feeding infusing via pump. The resident had white frothy secretions at her mouth and bubbling film at her tracheostomy opening. She made raspy gurgling sounds while inhaling and exhaling. Licensed Nurse (LN) H entered R27's room, put on gowns and gloves, assessed the resident, opened in line suction cannula, attached to suction machine connection tubing, and suctioned the resident's tracheostomy twice, clearing the line with sterile water with each pass. LN H provided mouth care/oral care. LN H reported the resident had infection in her sputum which was sent to laboratory for analysis. R27 received intravenous (IV) antibiotics. R27 has frequent congestion and required suctioning every two hours. On 10/01/24 at 10:07 AM, LN G verified R27's suction tubing in a drawer with the end of the suction connective tubing uncapped and stored directly on the bottom of the drawer,surrounded by various other medical supplies. LN G stated the tubing should be capped and stored when not in use to prevent contamination of the cannula and connective tubing. On 10/02/24 at 11:00 AM, Administrative Nurse F noted an uncapped and uncovered suction tube stored directly on the drawer bottom surrounded by various other medical supplies. She stated the tubing should be capped and stored when not in use to prevent contamination of the cannula and connective tubing. Administrative Nurse F reported she expected staff to follow orders and the suction tubing placed back into the wrapper should be labeled and dated. Cannulas should be capped when not in use. Storing cannula without caps when not in use is not appropriate. She confirmed the resident received antibiotic therapy for upper respiratory infection. On 10/02/24 at 12:30 PM, Administrative Nurse D reported staff should cap and store suction cannulas/ tubing when not in use in a manner to prevent cross contamination and infection. She confirmed storing a suction machine connective tubing and cannulas used for suctioning the resident's tracheostomy directly in the drawers was not appropriate to prevent infection. The facility's policy for Suctioning the Lower Airway (Endotracheal (ET) or Tracheostomy Tube), dated 05/2024, documentation included staff were to use sterile equipment to avoid widespread pulmonary and systemic infection. Suctioning of the lower airway is a sterile procedure. All equipment that comes in contact with the lower airway must be sterile. The facility failed to provide required respiratory care to this resident, which included tracheostomy care and tracheal suctioning, consistent with professional standards of practice related to the storage of suctioning cannulas/tubing to when not in use to prevent infection and cross contamination to prevent infection. - Review of Resident (R)3's Physician Orders, dated 08/07/24 revealed the following diagnoses that included chronic respiratory failure, extended spectrum beta lactamase (ESBL) resistance infection (microorganism/bacteria), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), carrier, or suspected carrier of methicillin resistant staphoccocus aureus (MRSA-microorganism/bacteria type infection), and tracheostomy (opening though the neck into the trachea through which an indwelling tube may be inserted). The Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating not able to complete interview, related to the resident rarely/never understood. He received special care and treatment which included oxygen, suctioning, and tracheostomy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 07/03/24, directed staff the resident with a tracheostomy (trach) related to impaired breathing mechanics. Staff were to monitor the resident for potential for respiratory infection. The suctioning tubing is to be put away properly to prevent infection/ related to contamination. The Physician Orders, dated 08/07/24, documentation included when trach suctioning, suctioning tubing is to be put away properly to prevent infection/contamination. Suctioning every two hours related to chronic respiratory failure with hypoxia (inadequate supply of oxygen). On 10/01/24 at 10:07 AM, Licensed Nurse (LN) G verified the suction tubing in R 3's drawer with the end of the suction connective tubing uncapped and stored directly on the drawer bottom surrounded by various other medical supplies. LN G stated the tubing should be capped and stored when not in use to prevent contamination of the cannula and connective tubing. On 10/02/24 at 12:30 PM, Administrative Nurse D reported staff should cap and store suction cannulas/ tubing when not in use in a manner to prevent cross contamination and infection. She confirmed storing suction machine connective tubing and cannulas used for suctioning the resident's tracheostomy directly in the drawers was not appropriate to prevent infection. The policy Suctioning the Lower Airway (Endotracheal (ET) or Tracheostomy Tube), dated 05/2024, documentation included use sterile equipment to avoid widespread pulmonary and systemic infection. Suctioning of the lower airway is a sterile procedure. All equipment that comes in contact with the lower airway must be sterile. The facility failed to provide required respiratory care to this resident, which included tracheostomy care and tracheal suctioning, consistent with professional standards of practice related to the storage of suctioning cannulas/tubing to when not in use to prevent infection and cross contamination to prevent infection.

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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** 36881 The facility reported a census of 34 residents. The sample of 14 residents included five residents reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure medications monitored and administered to treat Resident (R)19's heart failure. Findings included: - Review of Resident (R) 19's Physician Orders, dated 08/07/24, revealed diagnosis that included congestive heart failure. The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The resident rejected evaluation of care one to three days a week. The Quarterly MDS, dated [DATE], documented changes in the resident status which included a BIMS score of 13, which represented a decline in his cognition. R 19's Care Plan dated 08/29/24, directed staff the resident received multiple medications to treat his diagnoses. The staff should administer medications as ordered, monitor for side effects and effectiveness, notify the physician as ordered, consult with pharmacist, and discuss with the physician regarding ongoing need for use of medication. Staff were to educate the resident of risk of refusal of care. Review of R 19's Physician Orders, dated 08/07/24, included Metoprolol Succinate ER (Extended Release) Tablet 50 milligrams (MG), give one tablet, by mouth in the morning, related to heart failure. Hold medication and notify the Physician for a pulse of less than 60 and/or systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) of less than 110. Review of the Medication Administration Record, (MAR) dated 09/01/24 through 09/30/21, revealed R19 received Metoprolol medications outside of the physician prescribed parameters on 09/02/24 with SBP of 108, on 09/10/24 with SBP of 103, on 09/12/24 with SBP of 103, on 09/19/24 with SBP of 106, and 09/20/24 with SBP of 106, a total of five occasions. The MAR and electronic medical record (EMR) lacked documentation of R 19's physician notification of medications administered outside of the prescribed parameters. Additionally, the documentation revealed the resident refused Metoprolol on five occasions on 09/03/24, 09/05/24, 09/11/24, 09/26/24, and 09/28/24, and lacked physician notification, or documented evidence of education provided to the resident regarding benefits verses risks related to not taking his heart medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 03:10 PM, Licensed Nurse (LN) J verified the resident frequently refused his medication. She reported the resident stayed up late and became agitated when staff woke him to give him his medication. The anti-hypertensive medications had parameters for administration. LN J reported the physician orders indicated the resident the medication should be held if the resident's SBP less than 110, and/or pulse less than 60. She confirmed that if the resident's vital signs were outside of the parameters the medication should be held and the physician notified. On 10/02/24 at 02:57 PM, Administrative Nurse D reported staff should follow physician orders when they administer medication. She stated the staff should hold the medication when vital signs were outside of the prescribed parameters and notify the physician. The facility lacked a policy to address administering medications as the physician orders and/or staff notifying the physician of parameter outliers and resident refusal of medication. The facility failed to ensure medications monitored and administered to treat Resident (R)19's heart failure.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 28560 The facility reported a census of 34 residents. Based on observation, record review, and interview, the facility failed to ensure foods were stored, prepared, and distributed in a manner to prevent foodborne illness to the residents. Findings included: - Observation, on 09/30/24 at 10:02 AM, revealed the kitchen refrigerator contained six squirt bottles of condiments (salad dressings) that lacked coverings over the tips of the squirt bottles. Observation, on 10/02/24 at 10:57 AM, during environmental tour of the kitchen with Dietary Staff BB, revealed the following areas of concern: 1. The kitchen refrigerator contained six squirt bottles of condiments (salad dressings) that lacked coverings over the tips of the squirt bottles. 2. The kitchen handwashing sink contained a black substance along the back edge caulking and brown/yellow discolorations on the sink back edges. 3. The air fryer/convection oven contained splatters of a black substance on the upper interior surface. 4. The ice machine drain laid directly in the drain without a two-inch air gap. Interview, on 10/02/24 at 11:15 AM, Dietary Staff BB confirmed the above issues and Maintenance Staff U, confirmed the ice machine drain did not have a two-inch air gap between the drain. The facility policy Food Safety Requirements reviewed 10/2023, instructed staff all foods stored in the refrigerators will be covered, labeled and dated. The facility policy Sanitation instructed staff to maintain the food service area in a clean and sanitary manner. Equipment, food contact surfaces and utensils shall be washed to remove or completely looses soils by using manual or mechanical means. The facility failed to ensure foods were stored, prepared, and distributed in a manner to prevent foodborne illness to the residents.

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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 34 residents with 14 residents selected for review. Based on observation, interview, and record review, the facility failed to ensure staff provided incontinence care in a manner to prevent the spread of infection for one Resident (R)13 with an open wound on her sacrum (large triangular bone between the two hip bones). Findings included: - Review of Resident (R)13's medical record revealed diagnoses that included diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), heart failure, cerebral infarction (CVA/stroke) - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and sacral (large triangular bone between the two hip bones) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. R13 had impairment on one side of her upper extremities and required substantial to dependent assistance on staff for activities of daily living, incontinent of bowel and bladder and had a stage two pressure ulcer (a partial loss of skin resulting in a shallow open ulcer. The ADL (Activity of Daily Living) Functional/Rehabilitation Care Area Assessment (CAA), dated 05/26/24, assessed the resident with skin breakdown, incontinence of bowel and bladder and a pressure ulcer to her coccyx (small bone at the end of the spine in the sacrum). The Care Plan reviewed 08/21/24, instructed staff the resident required total assistance with personal hygiene. Observation, on 10/01/24 at 10:19 AM, revealed Certified Nurse Aide (CMA) M and Administrative Nurse E, provided incontinence care to the resident. The resident was incontinent of stool, and the stool was on the lower edge of the dressing on her sacrum. CNA M used peri wipes to cleanse the rectal area of stool, and Administrative Nurse E instructed CNA M to remove the soiled dressing. The sacrum contained an open wound, and CNA M then used a peri wipe to further cleanse the rectal area and wiped the resident from her rectum over the wound. Administrative Nurse E then cleansed the wound with wound cleanser and provided wound care. Interview, on 08/21/24 at 10:30 AM, with Administrative Nurse E, revealed staff should wipe incontinent residents from the front to back, but in this case, it would be appropriate to wipe away from the wound, so as not to contaminate the wound with stool. The facility policy Wound Care Guidelines reviewed 04/2024, instructed staff to provide care of wounds to promote healing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure staff provided this resident with bowel incontinence with appropriate incontinence care to prevent the spread of infection.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 28560 The facility reported a census of 34 residents. Based on observation and interview, the facility failed to maintain patient care equipment in safe operating conditions to ensure two residents, Resident (R)82 and R2's commode grab bars and over the toilet commode. Findings included: - Observation, on 10/01/24 at 03:30 PM, revealed Resident (R)2's the over the toilet commode contained four legs that wobbled when pressure applied to the armrests, making it unstable. Observation, on 10/01/24 at 03:51 PM, revealed commode grab bars in Resident (R)82's bathroom, were unstable and moved when the resident attempted to sit or rise from the commode. Interview, on 10/01/24 at 04:00 PM, with Administrative Staff A stated she would expect staff to enter a maintenance request into their electronic system for maintenance tasks. The facility lacked a policy for maintenance of commode grab bars and over the toilet commode. The facility failed to ensure the commode grab bars for R82 and over the toilet commode for R2 were maintained in a safe condition to prevent accidents.