STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175374	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastridge	604 1st Street Centralia, KS 66415

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility had a census of 17 residents. Based on observation, interview, and record review, the facility failed to ensure an environment free from accident hazards when the facility left the active steam table, heating up to 180 degrees Fahrenheit (F), unattended and accessible to residents in the area. The facility reported three cognitively impaired, independently mobile residents who could potentially access the steam table without staff knowledge. This deficient practice placed three cognitively impaired, independently mobile residents in Immediate Jeopardy, and others at risk. The facility also failed to ensure residents did not have access to an unlocked blanket warmer. Findings included: - On 08/10/25 at 10:00 AM, the facility dining room was empty of residents and staff. The steam table in the dining room was unattended and accessible to residents. The steam table lids had a measured temperature of 135 degrees F. Upon request, Dietary Staff BB and Administrative Staff A obtained a facility thermometer, and the steam table lids registered at 180 degrees F. The facility reported three cognitively impaired, independently mobile residents could potentially access the steam table without staff knowledge. On 08/10/25 at 10:10 AM, Administrative Staff A stated for the immediate time, she placed a staff member in the dining room to assure no residents got close to the steam table. Administrative Staff A stated staff would turn the steam table off after meals, and once it was cool, staff would not man the area until the table was turned back on for evening meal service. On 08/10/25 at 11:05 AM, Dietary Staff BB stated she turned on the steam table around 06:00 AM and left it on all day, until after supper, and then turned it off for the night. Dietary Staff BB stated she did not check the temperatures of the steam table. On 08/10/25 at 02:30 PM, barriers and caution tape surrounded the steam table. The barriers stayed in place through 08/12/25 until a plexiglass barrier was installed. The Centers for Medicare and Medicaid (CMS) “State Operations Manual” (SOM) recorded temperatures at 124 degrees F can cause a third-degree burn (serious burn which affects the outer layer of skin as well as the entire layer beneath and requires immediate medical attention) in three minutes of exposure; temperatures at 127 degrees F can cause third degree burn with one minute of exposure; temperatures at 133 degrees F can cause third-degree burn in 15 seconds of exposure, and water temperatures at 140 degrees F can cause a third-degree burn in five seconds of exposure. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility’s “Department Safety” policy, reviewed 02/2024, stated all electrical machines with heat producing elements must be turned off when not in use. The department manager is responsible for maintaining safety standards and notifying the Safety Officer in case of any safety hazard. All department associates shall report defective equipment, unsafe conditions, acts, or safety hazards to the supervisor in writing or verbally. On 08/10/25 at 01:43 PM Administrative Staff A received the Immediate Jeopardy (IJ) template and notified the facility failure to have the steam table with steam table lids registered at 135 degrees F with one thermometer and 185 degrees F from another, accessible from all sides, and had lack of staff monitoring placed the residents in immediate jeopardy at F689 and constituted substandard quality of care at CFR 483. 25. The facility submitted an acceptable immediate jeopardy removal plan on 08/10/25 at 02:21 PM, which included the following: 1. A staff member was placed in the dining room to ensure no residents got close to the steam table. 2. The steam tables have been shut off. Once it is cool, staff will not be in the area until the table is turned back on for the evening service meal. 3. A temporary barrier with cones, chairs, and caution tape to keep folks away from the area. 4. On 10/11/25, once local hardware/lumber yard stores are open, a board barrier will then be put up as a more secure yet temporary fix. 5. A long-term plan will be put in place, likely building up the partial wall that was already in place, to shield the steam table. The surveyor verified the above corrective actions were implemented while onsite on 08/10/25 at 02:30 PM, and the deficient practice remained at a “D” scope & severity. - On 08/11/2025 at 07:58 AM, observation revealed an unattended open room, without a door, which had an unlocked blanket warmer on a shelf, approximately 2 ½ feet (ft) from the floor, with a temperature reading on the front of the warmer of 157.8 degrees Fahrenheit (F). The top inside metal shelf of the blanket warmer was hot to the touch. The first thermometer, when pointed at the metal shelf, read 152.5°F. Administrative Nurse E verified the finding and stated it had never been a problem in the past. On 08/11/25 at 08:01 AM, Maintenance Staff (MS) U, when asked if he would temp the shelf with a second thermometer, stated the reading on the outside was 157°F and that was the right temperature inside the blanket warmer due to a company coming out and checking the temperature to make sure it maintained that temperature. On 08/11/2025 at 08:32 AM, Maintenance Staff U used a second thermometer to check the temperature of the metal shelf inside the blanket warmer, and it read 155°F. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 08/11/25 at 10:30 AM, Licensed Nurse (LN) H stated that she had not seen any resident enter the room where the blanket warmer was kept. On 08/11/25 at 01:36 AM, Certified Nurse (CNA) M stated she had never seen a resident go into the room where the blanket warmer was kept. On 08/11/25 at 10:40 AM, Administrative Nurse D stated that she did not feel the location of the unattended blanket warmer was a problem, as residents do not enter the room, but staff had moved it to a locked room. Upon request, the facility failed to provide an accident policy. How far off the floor was this shelf

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. The facility identified a census of 17 residents. The sample included eight residents. Based on record review and interview, the facility failed to provide a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. This placed the residents at risk of decreased quality of care.Findings included:- The Payroll Based Journaling (PBJ) report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2025 Quarter One indicated the facility did not have RN hours on 11/30/24, 12/22/24, 12/25/24, and 12/28/24.Upon review of the facility's actual working nursing schedule from November 2024 and December 2024, it was revealed that the facility failed to have RN coverage on 12/28/24.On 08/11/25 at 03:05 PM, Administrative Staff A provided licensed nurse and RN punch times for all dates documented above except on 12/28/24, when the facility failed to have an RN staff member on duty that day. On 08/12/25 at 09:45 AM, Administrative Nurse D stated and confirmed that the facility did have RN coverage for all the days that were in question, except on 12/28/24, when the facility did not have RN coverage for that day. Administrative Nurse D stated that either she or Administrative Nurse E did their best to cover RN hours when another RN was not available.The facility's Staffing policy dated 05/19 documented it was the policy of this facility that there would be sufficient staff available to provide nursing and related care to the residents. A registered nurse will be present in the facility for at least eight hours each day, seven days a week. During hours when a registered nurse was not in the building, nursing administration would be available.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility identified a census of 17 residents. The sample included eight residents. Based on observation, record review, and interview, the facility failed to ensure that daily posted nurse staffing data was posted daily.Findings included:- On 08/10/25 at 09:43 AM, upon the initial tour of the facility, it was noted that the daily posted nurse staffing hour sheet was dated Friday, 08/08/25.Upon request on 08/11/25, the facility was able to provide daily posted nurse staffing data from the prior 18 months, but was not able to provide a sheet for 08/09/25 and 08/10/25. On 08/12/25 at 09:47 AM, Administrative Nurse E stated that she typically provided the daily nursing hour staffing sheet to the night shift charge nurse. Administrative Nurse E stated she had been on vacation and just returned yesterday, and had realized that the sheets for the weekend had not been completed as they should have. The facility was unable to provide a policy regarding daily posted nurse staffing data.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility identified a census of 17 residents. The facility had one medication room and one medication cart. Based on observation, record review, and interview, the facility failed to ensure the medication cart was kept locked and secured when cognitively impaired and independently mobile residents were near the cart. This placed the residents at risk of accidental ingestion of medication and adverse reactions.Findings included:- On 08/10/25 at 09:44 AM, the medication cart near the nurse's station was left unlocked and unattended by staff. Resident (R) 14, a cognitively impaired, independently mobile resident, was near the medication cart.On 08/10/25 at 09:45 AM, Licensed Nurse (LN) G stated that the cart should always be locked when she was away from it. On 08/12/25 at 09:45 AM, Administrative Nurse D stated that the medication cart should never be left unlocked when staff were away from the cart. The facility's Medication Storage and Management policy dated 05/19 documented that medications and biologicals were to be stored safely, securely, and properly following the manufacturer's recommendations or those of the supplier. Medication rooms, carts, and medication supplies were to always be locked or attended by persons with authorized access.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 17 residents. The sample included eight residents, with one sampled resident reviewed for hospice. Based on observation, record review, and interview, the facility failed to ensure the hospice provider provided the facility with Resident (R) 3's hospice plan of care. This placed R3 at risk of inadequate end-of-life care.Findings included:- R3's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (HTN- elevated blood pressure), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).R3's Significant Change Minimum Data Set (MDS) dated 07/24/25 documented a Brief Interview for Mental (BIMS) score of 15, which indicated intact cognition. R3 required substantial assistance to be dependent on staff for her activities of daily living (ADL). R3 was on hospice services.R3's Functional Abilities Care Area Assessment (CAA) dated 07/26/25 documented the need for assistance with all ADLs. R3 did not ambulate and required a sit-to-stand lift (a specialized medical device designed to assist individuals with limited mobility in transitioning from a seated to a standing position) and occasional use of a Hoyer lift (total body mechanical lift) with transfers. R3 has worked with physical therapy and occupational therapy in the past after joint replacement (involves replacing a damaged or diseased joint with an artificial one) surgeries. R3 participates in a range of motion (ROM) exercise programs. R3 was admitted to hospice services on 07/16/25. R3 was at risk for further pain, and the need for more assistance with care, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), unmet care needs, and falls. R3's Care Plan, revised on 07/17/25, directed care staff that she had a terminal prognosis and was receiving hospice services. The Care plan directed staff that hospice would provide Durable Medical Equipment (DME) of briefs and wipes. Staff were directed hospice would provide medications of Losartan (a medication to treat HTN) 25milligrams (mg) daily, MiraLAX (laxative) 17 grams (gm) daily, potassium chloride (treatment for low potassium) 10 milliequivalent (mEq) daily, senna (laxative) 8.6mg daily, Lasix (a medication used to reduce fluid retention) 20mg daily, fentanyl patch (an opioid patch used to manage moderate to severe pain) 50 mg every 48 hours, and milk of magnesia (medication is used for a short time to treat occasional constipation) 30 milliliters (ml) every 24 hours as needed (PRN). The Care Plan directed staff to encourage a support system of family and friends. The Care Plan directed staff that the hospice nurse would visit up to two times a week and needed for additional cares, falls and death; the hospice nurse aide to visit two times a week for bathing; the hospice social worker would visit twice a month and PRN emergent psychosocial needs; the hospice physician as needed face to face and symptom management. The Care Plan directed staff that hospice would provide PRN Tylenol (pain reliever); hyoscyamine solution (medication used to relax muscles and reduce secretions), lorazepam liquid (medication used to treat anxiety); and roxanol (medication used to manage pain, restlessness, and air hunger). The Care Plan directed staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met.On 08/11/25 at 01:55 PM, review of the hospice provider binder revealed that the hospice provider failed to provide R3's hospice plan of care. On 08/11/25 at 02:08 PM, Licensed Nurse (LN) H stated that R3's hospice binder should have the plan of care in it. LN H stated she had called the hospice provider, and they emailed her the hospice plan of care and provided a copy. LN H stated she would place a copy of the hospice plan of care in R3's binder.On 08/12/25 at 09:45 AM, Administrative Nurse D stated that the hospice provider had recently had a changeover in staff, and the plan of care might have been overlooked and not put in the binder. Administrative Nurse D stated she would ensure to get the hospice plan of care placed in R3's binder.The Hospice Services Agreement dated 05/17/23 documented that hospice shall be solely responsible for initially certifying and recertifying as necessary, the resident's terminal illness in accordance with applicable law. Hospice shall be solely responsible for conducting initial and comprehensive assessments upon a resident's election of hospice care. Hospice shall be responsible for determining, and modifying as necessary, the appropriate hospice plan of care. Such hospice plan of care shall encompass all issues related to the terminal illness and related conditions. Hospice shall communicate with the resident, family members, facility staff, and the attending physician to develop and update the content of the hospice plan of care. Hospice shall determine the appropriate course of hospice care for residents who was under hospice's care, including any determination to change the level of services provided to such residents.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility identified a census of 17 residents. Based on record review and interview, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ) when the facility failed to submit accurate registered nurse (RN) and licensed nurse coverage 24 hours a day. Findings included:- The PBJ Staffing Data Report CASPER Report 1705D provided by the Centers for Medicaid and Medicare (CMS) for Fiscal Year (FY) 2025, quarter one and quarter two documented the following triggered areas: Quarter one: one-star staffing rating, no RN hours, and failed to have licensed nursing coverage 24 hours a day. The report documented no RN hours on 11/30/24, 12/22/24, 12/25/25, and 12/28/24.The report documented the facility failed to have a licensed nursing coverage 24 hours a day on 10/12/23, 10/13/24, 11/09/24, 11/23/24, 11/28,24, 11/30/24, 12/01/24, 12/14/24, 12/15/24,12/21/24, 12/22/24, 12/25/24, and 12/28/24Quarter two for FY 2025 triggered for failing to have licensed nursing coverage 24 hours a day on 02/09/25, 02/22/25, 02/23/25, 03/15/25, and 03/16/25.On 08/11/25 at 03:05 PM, Administrative Staff A provided licensed nurse and RN punch times for all dates documented above except on 12/28/24, when the facility failed to have an RN staff member on duty that day. On 08/12/25 at 09:45 AM, Administrative Nurse D stated that all nursing hours were sent to the corporate human resources person at the sister facility. Administrative Nurse D stated that at one point there had been an issue with the correct hours being submitted to CMS, but that she believed that issue had been resolved. Administrative Nurse D stated and confirmed that the facility did have 24-hour licensed nurse coverage for all the days that were in question, except on 12/28/24, when the facility did not have RN coverage for that day. Administrative Nurse D stated that either she or Administrative Nurse E did their best to cover RN hours when another RN was not available.The facility lacked a policy regarding PBJ Reporting.