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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175377 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Trinity Manor | | STREET ADDRESS, CITY, STATE, ZIP CODE 510 W Frontview Street Dodge City, KS 67801 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168</p> <p>The facility had a census of 40 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure two of five residents reviewed during the medication administration pass remained free of medication errors for Resident (R) 19 and R21. This placed the residents at risk for adverse reactions from the medication.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R19's Electronic Health Record (EHR) revealed diagnoses of dysphagia (swallowing difficulty), irritable bowel syndrome (IBS- abnormally increased motility of the small and large intestines), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). <p>R19's Annual Minimum Data Set (MDS), dated [DATE], recorded R19 had a Brief Interview for Mental Status score of 00 that indicated she had severely impaired cognition. The MDS recorded she required extensive assistance of two staff with activities of daily living (ADLs).</p> <p>R19's Care Plan, dated 12/31/24, recorded R19 required extensive assistance with most activities of daily living (ADL) care. R19's Care Plan documented the resident received a regular diet with pureed (a paste or thick liquid suspension usually made from cooked food ground finely) texture, and nectar thick consistency. The care plan documented to administer medication as ordered and observing for side effects.</p> <p>The Physician Order, dated 12/02/24, directed the staff to administer Protonix (reduce the amount of acid in the stomach) DR (delayed release) 40 milligram (mg), administer one, tablet one time a day for maintenance therapy.</p> <p>On 01/22/25 at 08:00 AM, License Nurse (LN) G crushed R19's morning medications including the Protonix, and placed the medications in a plastic medication cup then poured the pills in a plastic medication bag and crushed the medication. LN G next placed the crushed medication in the plastic medication cup and added applesauce. Continued observation revealed LN G administered the crushed medication to the resident.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 01/23/25 at 09:20 AM, LN G stated she administered R19 medications crushed because the resident had a hard time swallowing the pill whole. LN G verified that delayed-release medications should not be crushed and she would speak with the director of nursing to get another route of administration for the resident.</p> <p>On 01/23/25 at 09:25 AM, Administrative Nurse D verified that the extended-release medication should not be crushed and said it should be administered whole due to its extended release. Administrative Nurse D said she would have an in-service with the nurse regarding the proper route of medication.</p> <p>Medlineplus.gov directed that delayed-release and extended-release tablets should be taken whole; do not split, chew, or crush them.</p> <p>The facility's Crushing Medication policy, undated, documented medications shall be crushed only when appropriate and safe to do so, consistent with physician orders. The medical director and director of nursing, in conjunction with the consulting pharmacist, shall identify appropriate indications and procedures for crushing medications. The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long-acting or enteric-coated medications. That attending physician or consultant pharmacist must identify an alternative and/or dose form, or the attending physician must document (or provide the nurses with clinical pertinent reason to document) why crushing the medication would not adversely affect the resident; or when such medication is administered, the facility staff will observe the resident for pertinent adverse effects. Crushing each medication separately and administering each with food is considered best practice. Issues related to safety, needs preference, medication schedule, and functional ability will determine the most resident-centered approach.</p> <p>The facility failed to ensure R19 remained free from medication errors when staff crushed a delayed-release medication prior to administration. This placed the resident at risk for adverse reactions from the medication.</p> <p>- R21's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (dysphagia (swallowing difficulty), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).</p> <p>R21's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R21 had a Brief Interview for Mental Status score of 00 that indicated she had severely impaired cognition. The MDS recorded she required extensive assistance of one to two staff with activities of daily living (ADLs).</p> <p>R21's Care Plan, dated 01/03/25, recorded R21 required one to two assistance with most activities of daily living (ADL) care. R21s Care Plan documented the resident received a Low Concentrated Sweet (LCS) diet with pureed (a paste or thick liquid suspension usually made from cooked food ground finely) texture, and thin liquids. The care plan documented to administer medication as ordered and observe for side effects. The MDS recorded staff would monitor for and report any difficulty chewing/swallowing and report to speech therapy as needed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Physician Order, dated 01/07/25, directed the staff to administer Oxybutynin XL ER (extended-releaseextended release) 10 milligram (mg), administer one, tablet one time a day for overactive bladder.</p> <p>On 01/22/25 at 07:30 AM observation revealed License Nurse (LN) G crushed R21's morning medications including the Oxybutynin, and Oxybutynin and placed the medications in a plastic medication cup then poured the pills into a plastic medication bag and crushed the medication. LNG then placed the crushed medication back in the plastic medication cup and added applesauce. Continued observation revealed LN G administered the crushed medication to the resident.</p> <p>On 01/23/25 at 09:20 AM, LN G stated she administered R21 medications crushed because she had a hard time swallowing the pill whole. LN G verified extended-release medications should not be crushed and she would speak with the director of nursing to get another route of administration.</p> <p>On 01/23/25 at 09:25 AM, Administrative Nurse D verified the extended-release medication should not be crushed and said it should be administered whole due to the extended release of the medication. Administrative Nurse D said she would have an in-service with the nurse regarding proper route of medication.</p> <p>Medlineplus.gov directed that delayed-release and extended-release tablets should be taken whole; do not split, chew, or crush them.</p> <p>The facility's Crushing Medication policy, undated, documented medications shall be crushed only when appropriate and safe to do so, consistent with physician orders. The medical director and director of nursing, in conjunction with the consulting pharmacist, shall identify appropriate indications and procedures for crushing medications. The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long-acting or enteric-coated medications. That attending physician or consultant pharmacist must identify an alternative and/or dose form, or the attending physician must document (or provide the nurses with clinically pertinent reason to document) why crushing the medication would not adversely affect the resident; or when such medication is administered, the facility staff will observe the resident for pertinent adverse effects. Crushing each medication separately and administering each with food is considered best practice. Issues related to safety, needs preference, medication schedule, and functional ability will determine the most resident-centered approach.</p> <p>The facility failed to ensure R21 remained free from medication errors when staff crushed an extended-release medication prior to administration. This placed the resident at risk for adverse reactions from the medication.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>26768</p> <p>The facility had a census of 40 residents. Based on observation, interview, and record review the facility failed to store, prepare, and serve food in a sanitary manner for the 40 residents who received meals from the facility kitchen.</p> <p>Findings included:</p> <p>- On 01/21/25 at 07:48 AM, observation in the facility kitchen revealed:</p> <p>A refrigerator with an opened, partially used, undated plastic quart container of macaroni salad, undated, opened, and partially used bags of diced ham, and pre-cooked chicken pieces. The walk-in freezer had three boxes of food stored on the floor.</p> <p>On 01/22/25 at 10:45 AM, observation in the facility kitchen revealed the utensil drawers below the coffee maker had a piece of wrinkled paper towel, a brownish drip in a teaspoon, and a small amount of dried food particles. The drawers under a make table had plastic bins for scoops and ladles with dried food and spills in the bins. The walk-in freezer stall had two boxes of food on the floor. The kitchen had one of six fluorescent light covers with a large number of cracks.</p> <p>On 01/21/25 at 07:48 AM, Dietary Staff (DS) CC verified the bags of opened foods and salad should have been dated when opened. She verified food boxes should not be stored on the floor.</p> <p>On 01/22/25 at 10:48 AM, Dietary Staff (DS) BB verified the drawers needed cleaning and stated they had not included drawer cleaning on the schedule. She verified food boxes should not be stored on the floor in the freezer and stated the vendor delivered the foods on Thursdays (four days earlier). She stated maintenance had problems finding covers to fit these lights.</p> <p>The facility's Cleaning Rotation policy, dated 2011, stated drawers would be cleaned weekly.</p> <p>The facility's Food Storage policy, dated 2011, stated staff were to store deliveries as soon as they were inspected.</p> <p>The facility's Labeling/Dating Food policy, dated 2011, stated all foods stored would be properly re-dated with the date the item was opened and shall be used by the safe food storage guidelines.</p> <p>The facility failed to store, prepare, and serve food in a sanitary manner for the 40 residents who received meals from the facility kitchen.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p>37450</p> <p>The facility had a census of 40 residents. Based on observation, record review and interview, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as air-conditioning units in large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by legionella) which placed the residents at risk of contracting infectious processes.</p> <p>Findings included:</p> <p>- On 01/22/25 at 04:50 PM, Administrative Staff A reported the facility lacked a waterborne pathogen/Legionella program.</p> <p>The facility's Legionella Water Management Program dated 08/2023, documented as part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. The purpose of the water management program is used to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionella disease.</p> <p>The facility failed to implement a water management program and manage waterborne pathogens placing the residents who reside in the facility at risk for contracting Legionella pneumonia.</p> | | |