STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175439	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Seneca	512 Community Drive Seneca, KS 66538

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide dignified toileting care by leaving curtains and window blinds open for Resident (R) 3 and R16 during toileting activities, and R2 during suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) care. This placed the residents at risk for impaired dignity and decreased psychosocial well-being. Findings included: - R3's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Down's syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), abnormalities of gait and mobility, need for assistance with personal care, and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3's had severe cognitive impairment, dependent on staff for all functional activities and mobility. R3 was frequently incontinent of urine, always incontinent with bowel. The MDS further documented R3 received scheduled pain medication regimen and an anticonvulsant (a group of medications used to prevent seizures). R3's Care Plan, dated 03/17/25, documented R3 had an activities of daily living self-performance deficit related to diagnoses of dementia with behaviors and Down's syndrome. R3 was dependent on two staff for repositioning and turning, dressing, personal hygiene, and toileting. The care plan directed staff to check and change briefs, transfer with a Hoyer (total body mechanical lift) lift, but R3 only required one staff member for eating. On 04/28/25 at 12:00 PM, R3 was sitting in the dining room in her Broda chair (specialized wheelchair with the ability to tilt and recline) wearing a shirt with the side seam open, exposing her left side from mid waist area to breast fold, open two to three inches. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/25 at 08:44 PM, Certified Nurse Aide (CNA) M and CNA N took R3 into her room and closed the door to the hallway, then used a mechanical lift to transfer R3 from the Broda chair onto the bed. CNA M and CNA N proceeded to undress the resident from the waist down to check and change R3's brief. CNA M and CNA N provided incontinent care and brief change without drawing the curtain or the blinds to the window, which looked out to the patio and exit walkway. CNA M reported that staff placed a blanket across R3's lap when she was seated in the Broda chair, due to arm movements which would lift her shirt and expose her skin. On 04/30/25 at 08:11 AM, Administrative Nurse D stated her expectation of staff was to provide privacy for the residents during cares and in public places. The facility's Dignity policy, dated 09/26/24, documented the facility must treat each resident with respect and dignity and for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. - R16's Electronic Medical Record (EMR) included diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), history of falls, major depressive disorder (major mood disorder that causes persistent feelings of sadness), insomnia (inability to sleep), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with severe agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and abnormalities of gait and mobility R16's Quarterly Minimum Data Set (MDS), dated [DATE], documented R16 had severe cognitive impairment, had physical and verbal behaviors directed toward others, one to three days of the seven-day look-back period. R16 was dependent on staff for toileting hygiene and lower body dressing. The MDS further documented R16 was always incontinent of urine and bowel. R16's Care Plan, dated 03/25/25, documented R16 had an activities of daily living self-care performance deficit related to dementia. The care plan instructed staff that R16 required extensive assistance of two staff for toileting and transfers. On 04/29/25 at 09:02 AM, while R16 was sitting in her wheelchair in her room, Certified Nurse Aide (CNA) M and CNA O explained they would assist R16 into the bathroom for toileting. R16 commented on being undressed in public, CNA M and CNA O reassured R16 and explained they would take R16 into the bathroom before undressing so she would be able to sit on the toilet. The staff then proceeded to wheel R16 into her bathroom and assisted R16 onto the toilet. Once R16 was finished in the bathroom, CNA M and CNA O provided toileting hygiene, applied a brief, and pulled up lower body clothing. During the process, the open bathroom door was in visual line of the exterior window, through which the exit and walkway to the courtyard. Staff failed to close the window drapes or window shades. On 04/30/25 at 08:11 AM, Administrative Nurse D stated her expectation of staff was to provide privacy for the residents during cares and in public places. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Dignity policy, dated 09/26/24, documented the facility must treat each resident with respect and dignity and for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. 27168 - On 04/29/25 at 10:00 AM, observation revealed Certified Nurse Aide (CNA) N and CNA P positioned R2 flat in bed pulled her shirt up and pulled down her attends to expose above pubic area, then cleaned R2's urinary catheter tubing with peri wipes and repositioned the gauze sponge around the insertion of the catheter tubing. CNA N reattached the residents attends. The continued observation revealed the resident's two windows had the blinds half up and a visualization of the South Hall resident rooms/windows. On 04/30/25 at 08:00 AM, Administrative Nurse D stated staff should not provide personal cares for the residents without closing the blinds and providing the resident privacy. The facility's Dignity Policy, dated 09/26/2024, documented each resident has the right to be treated with dignity and respect, the interactions, and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating and resident's goals, preferences, and choices. The policy documented that staff must respect the resident's individuality as well as honor and value their input.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 39 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure an environment free from chemicals and hazards for four cognitively impaired, independently mobile residents who resided in the facility. Findings included: - On 04/28/25 at 09:00 AM, observation during initial facility tour revealed an unlocked housekeeping room door on the East Hall. The housekeeping room contained the following: Two 32-ounce (oz) bottles of Diversey clinging toilet bowl cleaner, with the warning may cause burns, damage to eyes, and be harmful if swallowed, and keep out of reach of children. One 32-oz bottle of Diversey [NAME] Sporicidal disinfecting cleaner, with the warning may cause severe skin burns and serious eye damage and may be corrosive to metals, and keep out of reach of children. One gallon jug of Prominence heavy-duty cleaner, with the warning may cause eye irritation, mildly irritating to skin, irritating to mouth, throat, stomach, and respiratory tract. One 15-oz spray can of IND/COM disinfectant cleaner, with the warning may cause skin and eye irritation, and potentially severe burns and damage, and keep out of reach of children. On 04/28 at 09:05 AM, Maintenance Staff U verified the chemicals in the unlocked housekeeping room and stated the housekeeping door should be locked and the chemicals were to be stored in a locked, secure location. Maintenance Staff U verified the door had a keypad on the hallway door side, and on the inside of the door, it had a lever that allowed it to be positioned to keep the door unlocked. Maintenance Staff U verified the inside door lever was turned to the unlocked position, which allowed the door to remain unlocked. On 04/30/25 at 08:00 AM, Administrative Nurse D verified that the housekeeping room should always be locked and chemicals should not be accessible to the residents. The facility Storage of Chemicals, dated 06/17/2024, documented the facility would store chemicals in accordance with manufacturer guidelines while maintaining supervision while in use. The policy documented the resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The policy documented the facility would maintain supervision of chemicals when in active use, and when not actively in use, would be stored out of reach of residents in accordance with Globally Harmonized System (GHS) for classification and Labeling of Chemicals. The policy recorded all flammable and combustible materials must be clearly labeled, and they must be stored in approved storage cabinets or inside a storage area.

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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** 32360 The facility had a census of 39 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician of blood sugars (a system which measures blood glucose in the body) outside of ordered parameters for one resident, Resident (R) 28 and failed to hold insulin (medication that lowers the level of glucose [a type of sugar] in the blood) when the medication was out of the physician ordered parameters. This placed the residents at risk for adverse effects related to medication. Findings included: - The Electronic Medical Record (EMR) for R28 documented diagnoses of Diabetes Mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (high blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Medicare 5 Day Minimum Data Set (MDS), dated [DATE], documented R28 had intact cognition. R28 required partial assistance of staff for upper body dressing, toileting, and ambulation. The MDS documented R28 received three days of insulin (a hormone that lowers the level of glucose in the blood) and seven days of antidepressant (a class of medications used to treat mood disorders) medication during the look-back period. R28's Quarterly MDS, dated [DATE], documented intact cognition. R28 required set-up assistance for eating, dressing, and personal hygiene. R28 received seven days of insulin and antidepressant medication during the lookback period. R28's Care Plan, dated 02/19/25, initiated on 05/09/24, directed staff to perform Accu-checks (blood glucose monitoring test) as ordered, administer medications as ordered, and provide her diet as ordered. The Physician's Order, dated 05/09/24, directed staff to notify the physician if R28's Accu-checks were below 70 milligrams (mg) per deciliter (dL) or above 400 mg/dL. R28's Medication Administrative Record, dated February 2025, documented R28's blood sugar was out of parameters and the physician was not notified for the following days. 02/15/25 - 61 mg/dl 02/18/25 - 48 mg/dl 02/21/25 - 56 mg/dl 04/23/25 - 52 mg/dl (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/27/25 - 55 mg/dl R28's Medication Administration Record, dated March 2025, documented R28's blood sugar was out of parameters, and the physician was not notified on the following day: 03/05/25 - 68 mg/dl The Physician's Order, dated 02/05/25, directed staff to administer Lantus (insulin) 20 units (U) at bedtime and hold if her blood sugar was less than 120 mg/dl. This order was discontinued on 02/26/25. R28's Medication Administration Record, dated February 2025, documented the following days R28 received her insulin when her blood sugar was out of the physician's ordered parameters: 02/18/25 at 08:04 PM - 100 mg/dl 02/20/25 at 07:15 PM - 99 mg/dl On 04/29/25 at 07:40 AM, Licensed Nurse (LN) G provided R28 her morning medication in her room without incident. On 04/29/25 at 11:55 AM, LN G stated R28's blood sugar parameters were standing orders provided at admission, and R28 has had problems with her blood sugars for a while. LN G verified R28 had received her bedtime Lantus when her blood sugar was out of parameters, and that staff should have notified the physician of her low blood sugars. On 04/30/25 at 07:53 AM, Administrative Nurse D stated she expected staff to follow the physician's orders and hold the Lantus medication if her blood sugars were out of parameters. She further stated that the physician should be notified if her blood sugar readings were out of parameters. The facility's Blood Glucose Monitoring policy, dated 09/23/24, documented, associates who obtain capillary blood glucose specimens would do so in accordance with their scope of practice and in accordance with all applicable local, state, and federal guidelines. Upon request, a policy for medication administration was not provided by the facility.

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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. 32358 The facility had a census of 39 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024, Quarter 1 and 2, indicated the facility had excessively low weekend nurse staffing Review of the facility's weekend nursing schedules for the above Quarters revealed the facility had adequate staffing. On 04/30/25 at 08:00 AM, Administrative Nurse D verified the facility had not submitted the correct information for weekend nursing staffing and stated Administrative Staff B was responsible for submitting the PBJ information. Administrative Nurse D stated the Centers for Medicare and Medicaid Services (CMS) had done a PBJ audit in December and had cleared the facility. The facility's Staffing Posting and Payroll Based Journal (PBJ) Submission Policy, revised 04/22/25, documented the facility maintained adequate staff on each shift to meet residents' needs, posts daily staffing data, and furnishes staffing information to the state as specified in the Federal regulations. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 39 residents. The sample size included 13 residents. Based on observation, record review, and interview, the facility failed to adhere to infection control procedures for R33 who had enhanced barrier precautions (EBP - an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and glove used during high contact resident care activities), and failed to adhere to personal cares and change gloves for Resident (R) 2 who had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and failed to adhere to infection control procedures when dietary staff placed a rubber dish tub on the table with dirty dishes while the residents were still eating their meal. This placed the residents at increased risk for infection. Findings included: - On 04/29/24 at 10:00 AM, observation revealed Certified Nurse (CNA) N and CNA P entered the room of R2, who was on EBP. Observation revealed a sign posted on the outside of the resident's room giving instructions on personal protective equipment (PPE - gown and gloves). The PPE equipment and supplies were located in a plastic storage tote outside the resident's room in the hallway. Continued observation revealed CNA N and CNA P donned gowns and gloves and entered the resident's room. CNA N cleansed the resident's suprapubic tubing (a thin flexible tube that drains urine from the bladder through a small incision in the lower abdomen) and cleaned around the tubing insertion site and the first few inches of the catheter tubing. Then reposition the gauze sponge around the catheter tubing. CNA N removed her gloves and washed her hands. On 04/29/25 at 10:10 AM, observation revealed CNA N and CNA P transferred R2 from her bed to the shower chair with a sit-to-stand lift. R2 stated she just had a BM, and CNA N removed the resident's incontinent brief and cleansed the resident with peri wipes, then lowered the R2 onto the shower chair. Continued observation revealed CNA N continued to wear the same gloves she cleaned the residents with and opened the closet doors, and got the residents' shirt, pants, then went to her dresser and got a pair of socks. CNA N proceeded to open the resident bathroom door with the same gloves still on and got an incontinent brief. CNA N then removed her gloves and used hand sanitizer, and transported the resident to the shower room. On 04/30/25 at 08:00 AM, Administrative Nurse D verified that the staff should wear PPE when providing care for R2 and should change their gloves after personal cares. Administrative Nurse D said the facility would do some education with the staff regarding wearing PPE for resident care and when to remove the gloves between personal cares. (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's Infection Prevention and Control Program policy, dated 06/13/2024, documented the facility has an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible, and reviews and updates the IPCP annually and as necessary. The facility has systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors. This system includes an ongoing system of surveillance designed to identify possible communicable diseases and infections before they can spread to other persons in the facility, and procedures for reporting possible incidents of communicable disease or infections. Written standards, policies, and procedures for the program, which must include, but are not limited to, hand hygiene procedures to be followed by staff involved in direct resident contact. The policy documented the facility would ensure staff followed the IPCP's standards and procedures (hand hygiene and appropriate use of PPE), while other needs were specific to particular roles, responsibilities, and situations, such as injection safety and point of care testing. Surveyor: [NAME], [NAME] - R33's Electronic Medical Record (EMR) documented that R43 had diagnoses of obstructive and reflux uropathy (a condition where the normal flow of urine through the urinary tract is blocked, while reflux uropathy (vesicoureteral reflux or VUR) is when urine flows backward from the bladder to the ureters (small tubular structure that drains urine from the bladder) and kidneys (a pair of organs in the abdomen which remove waste and extra water from the blood (as urine), and help keep chemicals (such as sodium, potassium, and calcium) balanced in the body) instead of flowing forward). R33's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R33 had short and long-term memory problems and severely impaired cognition. The MDS documented R33 had a urinary catheter, frequent incontinence of urine, and no urinary tract infection (UTI - infection in any part of the urinary system). R33's Care Plan, revised 04/22/25, documented R33 dependent on staff with toileting. The plan documented the resident had a urinary catheter and instructed staff to encourage R33 to drink fluids and administer medications as ordered. The plan instructed staff to observe R33 for signs or symptoms of a UTI, provide catheter care every shift, position the catheter bag and tubing below the level of the bladder, and check the catheter tubing for kinks. The plan documented R33 was on enhanced barrier precautions (EBP). Review of R33's clinical record revealed R33 had positive UTIs on 09/07/24,12/19/24, and 04/23/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/29/25 at 09:20 AM, Certified Nurse Aide (CNA) M and CNA O donned a gown, applied masks, and gloves outside R33's room door, then entered the room with a sit-to-stand lift. CNA M placed a lift jacket on R33, while CNA O took off R33's heel protector boots. CNA O unhooked R33's catheter bag from underneath the wheelchair seat, draped it over the sit-to-stand lift machine, and placed the strap around the back of R33's lower legs. CNA O slowly raised R33 with the lift machine control and transferred him over the toilet. CNA M pulled R33's pants down, removed the incontinent brief, placed it in the trash, removed and discarded gloves, then CNA O lowered the resident onto the toilet. CNA M both stepped out of the bathroom so the resident could have privacy. R33 reported he was done. CNA M provided back perineal care and catheter care, removed and discarded gloves, applied new gloves, then placed a new incontinent brief on the resident. CNA O left R33's room with her gown still on, went down the west hall to the soiled utility, stood outside the soiled utility, then removed her gown and placed it in the soiled utility room. On 04/29/25 at 09:22 AM, CNA O verified she had left her gown on when she left R33's room and stated she should have taken it off and discarded it in the resident's room. On 04/30/25 at 10:33 AM, Administrative Nurse D stated that if a resident was on EBP, staff should remove his/her gown before he/she exited R33's room. The facility's Enhanced Barrier Precautions (EBP) Policy, revised 04/22/25, documented EBP referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Personal protective equipment (PPE) for enhanced barrier precautions was only necessary when performing high-contact care activities. - On 04/28/25 at 12:06 PM, Dietary Staff (DS) BB placed a plastic tub of dirty dishes on a table where residents were eating their noon meal and continued to place dirty dishes in the pan from other tables. DS BB left the dirty dishpan on the table and asked residents who entered the dining room what they would like to drink. On 04/30/25 at 10:33 AM, Administrative Nurse D verified the above finding and stated she had been concerned also, so she asked Certified Dietary Manager (CDM) CC about the concern and was told staff could place the dirty dishpan on the table if it was only half full. On 04/30/25 at 10:43 AM, CDM CC stated staff should not place a dirty dishpan on a table with residents who are still eating. The facility's Infection Prevention and Control Program (IPCP) and Plan policy, revised 06/13/24, documented methods to reduce the risks associated with procedures, including applicable precautions, as appropriate, based on care, treatment, and service setting. 32358