STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175444	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

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 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. 45668 The facility identified a census of 47 residents. The sample included 12 residents, with one resident reviewed for dignity. Based on observation, interview, and record review, the facility failed to provide a dignified care environment for Resident (R) 35 and R43. This deficient practice placed the residents at risk for impaired dignity and quality of life. Findings Included: - On 02/24/25 at 07:23 AM, Certified Nurse Aide (CNA) PP stood over R35 during the breakfast meal service. CNA PP fed R35 her breakfast standing over her for the entirety of her meal. On 02/24/25 at 12:20 PM, R43 sat in her electric wheelchair with her lunch. An unidentified staff member stood over R43 several times during meal service to assist by feeding her meal due to R43's difficulty using the silverware. On 02/26/25 at 10:03 AM, CNA N stated staff should never stand over the residents while assisting them with their meals. CNA N stated staff should be seated next to them. On 02/26/25 at 10:15 AM, Licensed Nurse (LN) G stated staff were to sit next to the residents while assisting them with their meals during meal service. She stated staff were to sit at the residents' level to help assist them and provide dignity. On 02/26/25 at 11:30 AM, Administrative Nurse D stated staff were expected to sit next to the residents while assisting them with the meals. The facility's Resident's Rights policy revised 02/2024 indicated the facility was to ensure a care environment that promotes dignity, choice, and respect for all residents. The facility failed to provide a dignified care environment for R35 and R43. This deficient practice placed the residents at risk for impaired dignity and quality of life.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 47 residents. The sample included 12 residents, with two residents reviewed for accommodation of needs. Based on observation, record review, and interviews, the facility failed to provide wheelchair foot pedals for Resident (R) 16's wheelchair while pushing her in the hall. This placed R16 at an increased risk for preventable falls and injuries. Findings included: - R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin was made, or the body cannot respond to the insulin), sleep apnea (a disorder of sleep characterized by periods without respirations), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), muscle weakness, unsteadiness on feet, need for assistance with personal care, cognitive communication deficit, hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R16 was impaired on both sides of her body in her upper extremities. The MDS documented R16 was dependent on staff for toileting and needed substantial to maximum assistance with bathing. The Annual MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS documented R16 was impaired on both sides of her body in her upper extremities. The MDS documented R16 was dependent on staff for toileting and showers and required setup for eating and oral hygiene. R16's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 07/19/24 documented staff were to continue to assist R16 with activities of daily living (ADL) and her mobility. The CAA documented staff were to ensure R16 was under standard fall precautions and were to monitor for decline in functional abilities and report to the physician immediately. Staff were to ensure R16 had breaks while performing ADLs. The CAA documented staff were to ensure R16's call light was within her reach. The Care Plan dated 08/30/21 documented staff were to ensure R16 was wearing appropriate non-skid footwear when ambulating or mobilizing in a wheelchair. R16's plan of care dated 12/26/23 documented R16 required assistance with ADLs related to her diagnosis. On 02/24/25 at 07:34 AM, R16 was pushed to her room from breakfast by Licensed Nurse (LN) G without foot pedals. LN G asks R16 to hold her feet up. On 02/24/25 at 12:43 PM, R16 was pushed up hall 300 to eat lunch without her foot pedals on her wheelchair by Certified Nurse's Aide (CNA) S. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 at 09:56 AM, CNA M stated some of the residents do not like having the foot pedals applied to their wheelchairs. CNA M stated staff should let the residents pedal themselves if they wish to not have pedals placed on their chairs. On 02/26/25 at 10:14 AM, LN G stated residents should have foot pedals on wheelchairs if staff are pushing the wheelchair. She stated pushing residents with pedals would be the safest. On 02/26/25 at 11:23 AM, Administrative Nurse D stated that many of our residents do not like having foot pedals on their wheelchairs. She stated that this should be care planned if residents do not want the foot pedals and staff are pushing the wheelchair. The facility's Accidents and Supervision policy, dated 02/01/20, documented that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. The facility failed to provide wheelchair foot pedals for R16's wheelchair while pushing her in the hall. This placed R16 at increased risk for preventable falls and injuries.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 47 residents. The sample included 12 residents, with 12 residents whose Minimum Data Set (MDS) were reviewed. Based on observation, record review, and interviews, the facility failed to complete an accurate MDS assessment for Resident (R) 35's status regarding admission to hospice services. This deficient practice placed R35 at risk for inappropriate care planning and care needs. Findings included: - R35's Electronic Medical Record (EMR) from the Diagnosis tab documented 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), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Significant Change MDS dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R35 was dependent on staff assistance for her activities of daily living (ADL). R35's MDS lacked indication she had received hospice services during the observation period. R35's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 12/20/24 documented she was dependent on staff assistance for ADLs. R35's Care Plan dated 11/19/24 documented staff would consult with hospice if her pain was not controlled with the present medication regimen. R35's EMR under the Orders tab revealed the following physician orders: Admit to hospice services on 11/14/24. On 02/25/25 at 01:10 PM, R35 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table after lunch. On 02/26/25 at 11:31 AM, Administrative Nurse D stated the person who completed the MDS nurse worked remotely. Administrative Nurse D stated the facility would notify the MDS nurse after a resident was admitted to a hospice provider. Administrative Nurse D stated she would have expected a modification would have been completed for the Significant Change MDS dated [DATE] which would have R35 had received hospice services during the observation period. The facility's MDS 3.0 Completion policy dated 03/24/23 documented the residents are assessed, using a comprehensive assessment process, to identify care needs and to develop an interdisciplinary care plan. Significant Change in Status Assessment is required when a resident enrolls in a hospice program or changes hospice providers and remains in the facility, or a resident in the facility receiving hospice services discontinues those services (known as revocation of hospice care) and remains in the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to accurately document R35's status on the MDS for her admission to hospice services. This deficiency placed R35 at risk for inappropriate care planning and care needs.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 47 residents. The sample included 12 residents, with one resident reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure staff assisted Resident (R) 16 with grooming and face shaving. This deficient practice placed R16 at risk for impaired dignity, comfort, and a further decline in ADLs. Findings Included: - R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), sleep apnea (a disorder of sleep characterized by periods without respirations), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), muscle weakness, unsteadiness on feet, need for assistance with personal care, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R16 was impaired on both sides of her body in her upper extremities. The MDS documented R16 was dependent on staff for toileting and needed substantial to maximum assistance with bathing. The Annual MDS dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R16 was impaired on both sides of her body, in her upper extremities. The MDS documented R16 was dependent on staff for toileting and showers and required setup for eating and oral hygiene. R16's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 07/19/24 documented staff were to continue to assist R16 with ADLs and her mobility. The CAA documented staff were to ensure R16 was using the standard fall precautions and were to monitor for decline in functional abilities and report to the physician immediately. Staff were to ensure R16 had breaks while performing ADLs. The CAA documented staff were to ensure R16's call light was within her reach. R16's Care Plan dated 12/26/23 documented R16 required assistance with ADLs related to her diagnosis. R16's plan of care documented she often refuses a bath or shower, and staff were to remind her of the importance of hygiene. Staff were to offer R16 a washcloth and soapy water for a sponge bath. R16's EMR lacked documentation of refusals for bathing or shaving her face. On 02/24/25 at 08:55 AM, R16 sat in the hallway waiting to go back to her room. R16's hair was matted to the right side of her head, her blue shirt had food on the front of it. R16's face had long gray whiskers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/24/25 at 11:44 AM, R16 sat in her room in her wheelchair, R16's face remained with food on her shirt and face, and her face remained unshaven. On 02/26/24 at 09:56 AM, Certified Nurse Aide (CNA) M stated all residents should have clean clothes, their hair combed, and their face shaved. She stated it was the CNAs who ensured residents had clean clothes and shaved. CNA M stated if a resident refused care the CNA M would inform the nurse. On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated all residents should be clean, and shaven and have their hair combed. LN G stated it was all staff duty to ensure residents were well groomed. LN G stated the CNAs have bathing sheets, if a resident refused grooming or bathing, the CNA would put that on the sheet and turn the sheet in to the Director of Nursing. On 02/26/25 at 11:23 AM, Administrative Nurse D stated it was all nursing staff's duties to ensure all residents were clean, were offered bathing, and the resident's faces were shaven. Administrative Nurse D stated residents' preferences to have their face shaved should be placed on the care plan, and refusals for bathing or care should be documented. The facility's Activities of Daily Living (ADL) dated 12/24/24 documented that the facility would ensure a resident's abilities in ADLs would not deteriorate unless deterioration was unavoidable. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility would maintain the individual objectives of the care plan and would review the care plan as needed. The facility failed to ensure staff assisted R16 with grooming and facial shaving. This deficient practice placed R16 at risk for impaired dignity and a further decline in ADLs.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 45668 The facility identified a census of 47 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to develop and implement individualized activities programming based on resident preferences for the residents on weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. Findings Included: - A review of the facility's Activity Calendars for December 2024, January 2025, and February 2025 was completed. The calendars revealed church services, coloring, puzzles, and movies were provided on Sundays. The calendars revealed reminiscing, coloring, puzzles, and independent activities were provided on Saturday. On 02/25/25 at 10:30 AM the facility's Resident Council reported activities on the weekends were inconsistent compared to weekdays. The council reported the facility lacked staff-led activities on Saturdays and Sundays when direct care staff got busy. The council reported the facility would provide coloring pages and puzzles. The council reported weekends were slow without staff-led activities to keep the residents busy. The council reported staff would often turn on the television for the residents on the weekends when staff-led activities were not held. On 02/26/25 at 10:30 AM the facility held a bowling activity in the dining hall. On 02/26/25 at 10:06 AM, Certified Nurse's Aide (CNA) N stated staff were expected to provide the activities on weekends. She stated the activities schedules were posted on the wall and staff could provide direct activities if they chose. She stated there was no staff assigned to provide activities on the weekends, but the Activities Coordinator (AC) was responsible for planning and ensuring they were completed. On 02/26/25 at 10:15 AM, Licensed Nurse (LN) G stated the kitchen staff often held the activities on weekends. She stated the residents were provided movies, coloring pages, puzzles, and sometimes played games on the weekend. On 02/26/25 at 11:14 AM, Activity Staff Z stated the unit staff were expected to complete the weekend activities for the residents. She stated staff could provide activities not on the calendars if they wanted to including finger painting, music therapy, and going outside. The facility was unable to provide a policy related to activities as requested on 02/26/25. The facility failed to develop and implement individualized activities programming based on residents' interests and preferences. This placed the affected residents at risk for boredom, isolation, and decreased quality of life.

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	175444	A. Building B. Wing	02/26/2025

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 47 residents. The sample included 12 residents, with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician's order for weekly weights to monitor Resident (R) 17 for fluid overload. This deficient practice placed R17 at risk for delay in treatment related to fluid overload and untreated illness. Findings included: - R17's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), muscle weakness, obesity (excessive body fat), hypoxia (inadequate supply of oxygen), unsteadiness on feet, fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 12 which indicated moderately impaired cognition. The MDS documented R17 had impairment on both sides of her body. The MDS documented R17 required partial to moderate assistance with toileting. The MDS documented R17 received a diuretic (medication to promote the formation and excretion of urine) during the observation period. The Significant Change MDS dated [DATE] documented R17 had a BIMS of 14 which indicated intact cognition. The MDS documented R17 was impaired on both sides of her body. The MDS documented R17 required clean-up assistance with toileting. The MDS documented R17 received a diuretic during the observation period. R17's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 05/06/24 documented R17 was monitored for complications associated with incontinence, toileting hygiene, and toileting transfers. The CAA documented the physician would be notified of any changes in patient skin and activities of daily living (ADL). The CAA documented peri care and brief changes would be administered by staff. R17's Care Plan dated 05/02/24 documented R17 had CHF, and desired to lose weight through diuretics. R17's plan of care documented staff would monitor R17's weight. R17's plan of care documented staff would weigh R17 weekly, per the recommendation of the physician related to diuretic use. R17's plan of care dated 07/19/23 documented staff would administer diuretic medications as ordered by the physician and monitor for side effects and effectiveness every shift. R17's EMR under the Orders tab dated 04/27/21 revealed the following physician orders: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Torsemide (diuretic) tablet 40 milligrams (mg); give one tablet by mouth in the morning for CHF dated 01/16/24. Weekly weights every Thursday dated 11/7/24. Review of R17's Medication Administration Record (MAR) from 11/07/24 to 02/25/24 (15 weeks) lacked evidence staff measured and recorded R17's weight on the following dates 12/19, 12/26, 01/09, 01/23, 01/30, 02/20. R17's clinical record lacked documentation of physician notification the weekly weights were not obtained and lacked evidence R17 refused to be weighed. On 02/25/25 at 08:19 AM R17 sat on the side of her bed, waiting for her breakfast to arrive in her room. On 02/26/24 at 09:56 AM, Certified Nursing Aide (CNA) M stated nursing would let the CNA staff know if a resident needed to be weighed. CNA M stated the nurses usually made a list of residents who needed to be weighed. CNA M stated if the resident was not weighed on the date scheduled, the CNA would try to get the weight the following day. On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated the weights for residents are on the nursing Treatment Administration Record (TAR). She stated the nurse would let the CNAs know what residents needed to be weighed each morning. LN G stated she would not notify the physician of non-completed or refusal of weights. On 02/26/25 at 11:23 AM, Administrative Nurse D stated the CNAs got the residents' weight as each resident would get up in the morning. She stated the weights were given to the nurse to put in the resident's EMR. Administrative Nurse D stated if a nurse was unable to obtain the weight, the physician would be notified. The facility's Provision of Physician Ordered Services dated 12/12/24 documented that this policy was to provide a reliable process for the proper and consistent provision of physician-ordered services according to professional standards of quality. The facility failed to follow a physician's order for weekly weights to monitor R17 for fluid overload. This deficient practice placed R17 at risk for a delay in treatment related to fluid overload and untreated illness.

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	175444	A. Building B. Wing	02/26/2025

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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** 45668 The facility reported a census of 47 residents. The sample included 12 residents, with 5 reviewed for accidents. Based on observations, record reviews, and interviews, the facility failed to ensure a safe care environment related to the following Residents (R) 29, R33, and R32. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - The Medical Diagnosis section within R29's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), type two diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cognitive-communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), weakness, and history of falls. R29's Quarterly Minimum Data Set (MDS) completed 02/03/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she had bilateral lower extremity impairment. The MDS noted she used a wheelchair for mobility. The MDS noted she required total staff assistance for bathing, toileting, bed mobility, dressing, transfers, and personal hygiene. The MDS noted she was at risk for falls and had one minor injury fall. R29's Falls Care Area Assessment (CAA) completed 12/27/24 noted she was at risk for falls related to her medical diagnoses, medications, and a recent fall. The CAA noted a plan was created to minimize the risk. R29's Care Plan initiated on 10/14/21 indicated she was dependent on staff assistance for meals, oral hygiene, toileting, bathing, dressing, personal hygiene, transfers, and wheelchair mobility. The plan noted she was at risk for falls related to her impaired mobility and gait problems. The plan noted she had a history of unwitnessed non-injury falls. The plan instructed staff to ensure her call light was within reach and her room remained clutter-free. The plan noted she had a non-skid strip placed on the floor next to her bed and used a fall mat while in bed. The plan noted she had a non-injury fall from her bed on 01/31/25 and was to have a perimeter mattress to reduce the risks of further falls. On 02/25/25 at 08:30 AM, an inspection of R29's room was completed. R29's bed was in a low position with her fall mat against the wall. Her room had a non-skid strip on the floor next to her bed. R29's bed lacked a perimeter mattress. On 02/26/25 at 09:08 AM, an inspection of R29's bed revealed no perimeter mattress. On 02/26/25 at 09:10 AM, Certified Nurse Aide (CNA) Q stated staff should inspect each resident's room to ensure the fall interventions were in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175444	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated staff were expected to ensure all fall interventions were in place during each shift. She stated all direct care staff had access to the care plans and were expected to follow the interventions. On 02/26/25 at 11:23 AM, Administrative Nurse D stated staff were expected to review each resident's care plans and ensure the implemented interventions were in place. The facility's Accident and Supervision policy revised 01/2024 indicated the facility provided an environment free from potential accidents. The policy indicated that at-risk residents would be provided with individualized care plan interventions. The policy indicated staff would ensure the interventions were implemented correctly and consistently. The facility failed to ensure a safe care environment related to following R29's preventative fall interventions. This deficient practice placed R29 at risk for preventable falls and injuries. - The Medical Diagnosis section within R33's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), insomnia (difficulty sleeping), and repeated falls. R33's Quarterly Minimum Data Set (MDS) completed 12/02/24 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she had bilateral upper and lower extremity impairments. The MDS noted she used a wheelchair. The MDS noted she was totally dependent on staff assistance for bathing, dressing, bed mobility, transfers, personal hygiene, and toileting. The MDS noted no falls since her last assessment. R33's Falls Care Area Assessment (CAA) completed 11/18/24 indicated she was at high risk for falls related to her medical diagnoses, medications, and history of falls. The CAA indicated that a care plan was completed to reduce the risks related to falls. R33's Care Plan initiated on 10/18/22 indicated she was dependent on staff assistance for meals, oral hygiene, toileting, bathing, dressing, personal hygiene, transfers, and wheelchair mobility. The plan noted she transferred with a Sit-to-Stand lift. The plan noted she was at risk for falls related to her impaired mobility and gait problems. The plan instructed staff to anticipate her needs, ensure her room was free from clutter, and have a fall mat next to her bed. The plan noted she was to keep a Dycem (non-slip mat used for stabilization and grip to prevent slipping) mat in her wheelchair related to an unwitnessed fall on 11/22/22. The plan noted her wheelchair was switched to a Broda chair (specialized wheelchair with the ability to tilt and recline) on 10/18/23. On 02/25/25 at 08:02 AM, R33 sat in her Broda chair in front of the television in the main lobby area. R33's chair had no Dycem underneath her. On 02/26/25 at 09:08 AM, R33 was moved from her Broda chair to her bed. R33 had no Dycem in her chair. On 02/26/25 at 09:10 AM, Certified Nurse Aide (CNA) Q stated sometimes the Dycem didn't get transferred or put back in place after moving her from her bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175444	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated staff were expected to ensure all fall interventions were in place during each shift. She stated all direct care staff had access to the care plans and were expected to follow the interventions. She stated that R33's chair was switched to a broad chair and may not have needed the Dycem. On 02/26/25 at 11:23 AM, Administrative Nurse D stated staff were expected to review each resident's care plans and ensure the implemented interventions were in place. The facility's Accident and Supervision policy revised 01/2024 indicated the facility provided an environment free from potential accidents. The policy indicated that at-risk residents will be provided with individualized care plan interventions. The policy indicated staff will ensure the interventions were implemented correctly and consistently. The facility failed to ensure a safe care environment related to following R33's preventative fall interventions. This deficient practice placed R33 at risk for preventable falls and injuries. 41037 - R32's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of unsteadiness on feet, muscle weakness, fractured right femur (broken thigh bone), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Significant Change Minimum Data Set (MDS) dated [DATE] documented R32 had severely impaired cognition. The MDS documented R32 had no falls since admission or the previous MDS. The MDS documented R32 was dependent on staff assistance for transfers and bed mobility during the observation period. The MDS documented R32 had no limitation in her functional range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The Quarterly MDS dated [DATE] documented R32 had severely impaired cognition. The MDS documented that R32 had no falls since admission or the previous MDS. The MDS documented R32 had limited ROM in her bilateral extremities. The MDS documented R32 was dependent on staff for transfers and bed mobility. R32's Falls Care Area Assessment (CAA) dated 03/25/24 documented she was a high fall risk, and she was unaware of safety issues. R32 had not had a fall since 05/01/23. R32's Care Plan dated 08/05/22 documented she had an unwitnessed fall and directed the nursing staff to place a fall mat on the floor beside her bed and place the bed in the lowest position. The plan of care directed the nursing staff to be sure her call light was within her reach and to respond promptly to all requests for assistance. The plan of care dated 11/08/22 documented R32 had an unwitnessed fall and had obtained laboratory work. The plan of care dated 04/18/23 documented R32 had an unwitnessed fall and her antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication was restarted. The plan of care dated 05/11/23 documented R32 had an unwitnessed non-injury fall and directed staff to assist her to the bathroom immediately after meals and before bedtime. The plan of care dated 01/03/25 R32 had a witnessed fall and directed the nursing staff to use foot pedals on her wheelchair when staff pushed her wheelchair. (continued on next page)

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	175444	A. Building B. Wing	02/26/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's EMR under the Progress Notes tab revealed the following Einteract Situation, Background, Assessment, Recommendation (SBAR) summary for providers situation note dated 01/03/25 at 10:20 AM documented R32 had a fall, and the intervention was to use foot pedals when pushing her in the wheelchair. On 02/24/25 at 11:53 AM, R32 sat asleep in her wheelchair, in her room. R32's two call lights were pinned onto the call light cords on the other side of her bed, out of her reach. On 02/25/25 at 07:36 AM, Certified Nurse Aide (CNA) M pushed R32 from her room to the dining room in her wheelchair without foot pedals on the wheelchair. R32's feet slid on the floor as CNA M pushed her to the dining room. On 02/26/25 at 09:55 AM, CNA N stated a resident's call light should always be within their reach. CNA N stated everyone had access to the resident's care plan. CNA N stated the fall interventions could be found on the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA N stated some residents were able to propel themselves in their wheelchairs and did not use foot pedals. CNA N stated the nursing staff should use foot pedals when pushing the resident in their wheelchair if a resident cannot lift their feet. On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated the residents should have foot pedals on their wheelchairs when staff pushed the residents. LN G stated a resident's call light should always be within their reach. LN G stated it was the nurse's responsibility to ensure the fall interventions were in place. On 02/26/25 at 11:31 AM, Administrative Nurse D stated she would expect R32 to have foot pedals on her wheelchair when staff pushed the chair. Administrative Nurse D stated that R32 had fallen out of her wheelchair on 01/03/25 when hospice staff was pushing R32 to the shower room. Administrative Nurse D stated that R32 had put her feet down and fell forward out of her wheelchair. Administrative Nurse D stated call lights should always be placed within a resident's reach. The facility's Accidents and Supervision policy dated 02/02/20 documented that the resident environment remained as free of accident hazards as possible. Each resident received adequate supervision and assistive devices to prevent accidents. These included: identifying hazards and risks, evaluating, and analyzing hazards, implementing interventions to reduce hazards and risks, monitoring for effectiveness, and modifying interventions when necessary. The facility failed to ensure R32's foot pedals were placed on her wheelchair when pushed her to the dining room. The facility further failed to ensure R32's call light was within her reach. These deficient practices placed R32 at risk of falls and possible injuries.

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	175444	A. Building B. Wing	02/26/2025

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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** 49634 The facility identified a census of 47 residents. The sample included 12 residents, with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 15's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask and nasal cannula were stored in a sanitary manner. This placed R15 at an increased risk for respiratory infection and complications. Findings included: - R15's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), myocardial infarction (heart attack), rhabdomyolysis (breakdown of damaged skeletal tissue), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), assistance with personal care, muscle weakness, hypertension (high blood pressure), unsteadiness of feet, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R15 was impaired on both sides of her body. The MDS documented R15 was dependent on staff for bathing and needed substantial to maximum assistance for toileting and oral hygiene. The Annual MDS dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R15 required set-up and clean-up assistance for eating, bathing, and dressing. R15 required substantial to maximum assistance for toileting. R15's The Functional Abilities (Self-care and Mobility) Care Area Assessment (CAA) dated 04/09/24 documented staff would continue to assist R15 with care. R15's Care Plan dated 12/04/22 documented R15 required the use of supplemental oxygen and was at risk for complications. R15 would maintain adequate oxygenation daily. R15's plan of care documented staff were to change oxygen tubing and rinse filters weekly. R15's plan of care lacked documentation for storing the nebulizer when not in use. R15's EMR under the Orders tab revealed the following physician orders: Nursing was to change oxygen (O2) or nebulizer tubing and rinse the filter weekly, every Sunday night shift, and date each component. For oxygen use, nursing was to date tubing when changed and to add the number of liters ordered for the resident to the sticker on the tank, dated 04/09/23. (continued on next page)

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	175444	A. Building B. Wing	02/26/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ipratropium-Albuterol inhalation solution (medication inhaled to open airways) 2.5-3.0 give 3 milligrams (mg)per 3 milliliters (ml) nursing to give one vial nebulizer every six hours for wheezing as needed and shortness of breath, dated 04/19/24. On 02/24/25 at 07:35 AM, R15 laid on her bed asleep, with her nasal cannula in place. R15's nebulizer mask laid directly on her bedside table. At the bottom of R15's bed sat an oxygen tank. The green oxygen tank sat on a stand, and a nasal cannula was wrapped around the handle. R15's nebulizer mask and nasal cannula were not stored in a sanitary manner. On 02/26/25 at 09:56 AM, Certified Nurse Aide (CNA) M stated staff should place the nebulizer and nasal cannula, when not in use, in a bag labeled with the resident's name. On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated all respiratory equipment should be placed in an appropriate bag, labeled with the resident's name when the resident was not using the equipment. On 02/26/25 at 11:23 AM, Administrative Nurse D stated all staff were responsible for ensuring the respiratory equipment not in use was contained in a sanitary bag. The facility's Oxygen Administration policy dated 01/08/24 documented oxygen was administered to residents who needed it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Staff would perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Staff would follow manufacturer recommendations for the frequency of cleaning equipment filters, and change oxygen/mask weekly and as needed. Staff were to keep delivery devices covered in plastic bags when not in use. The facility failed to ensure R15's nebulizer mask and nasal cannula were stored in a sanitary manner. This deficient practice placed R15 at an increased risk for respiratory infection and complications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175444	A. Building B. Wing	02/26/2025

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Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 41037 The facility identified a census of 47 residents. The sample included 12 residents and five Certified Nurse Aides (CNA) reviewed for yearly performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure one of the five CNA staff reviewed had yearly performance evaluations completed. This deficient practice placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNA was employed with the facility for more than 12 months: CNA O, hired 03/06/23, had no yearly performance evaluation upon request. On 02/26/25 at 11:31 AM, Administrative Nurse D stated she was responsible for completing the nursing staff's yearly performance reviews. Administrative Nurse D stated CNA O worked nights. Administrative Nurse D stated she had not completed CNA O's yearly performance review. The facility's Required Training, Certification and Continuing Education of Nurse Aides policy dated 03/01/24 documented it was the policy of the facility to comply with State and Federal regulations and requirements as they pertained to the training, certification, and continuing education of its nurse aides. In-service training would be provided by qualified personnel and be based on the needs of the residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. The facility failed to ensure one of the five CNA staff reviewed had the required yearly performance evaluations completed. This deficient practice placed the residents at risk for inadequate care.

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	175444	A. Building B. Wing	02/26/2025

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 47 residents. The sample included 12 residents, with four reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record reviews, and observations, the facility failed to provide dementia-related care services for Resident (R) 91 to promote the resident's highest practicable level of well-being. This deficient practice placed R91 at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - The Medical Diagnosis section within R91's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), thrombocytopenia (abnormally low number of platelets, the parts of the blood that help blood to clot, sometimes associated with abnormal bleeding), kidney disease (damage to the kidneys that impairs their ability to filter waste products from the blood and produce urine), hypokalemia (low level of potassium in the blood), hyperlipidemia (condition of elevated blood lipid levels), muscle weakness, difficulty in walking, unsteadiness on feet, lack of coordination, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R91's EMR indicated she was admitted on [DATE]. R91's EMR indicated Admission Minimum Data Set (MDS) was in process. R91's EMR indicated the Care Area Assessments (CAA) were not completed due to her new admission. R91's Care Plan initiated 02/11/25 indicated she resided on the Memory Care Unit related to her severe cognitive impairment. The plan noted she had poor safety judgment and was a risk for elopement. The plan noted she wore a Wander Guard (a bracelet that helps monitor residents who are at risk of wandering) bracelet due to her elopement risk. The plan instructed staff to provide meaningful activities, directional cues, and activities to distract the resident from elopement behaviors. On 02/24/25 at 07:00 AM, R91 wandered around the secured Memory Care Unit. R91 went into R32's room and began digging through R32's personal items in the room. Staff directed R91 to come out of R32's room and sit at the table for breakfast. On 02/25/25 at 08:30 PM, R91 was left unsupervised by the Memory Care close to the patio exit doors. Upon hearing the facility's fire alarm, R91 attempted multiple times to open the patio door without staff intervention. On 02/25/25 at 09:07 AM, R91 was left alone to push on the patio doors without staff intervention. On 02/25/25 at 01:14 PM, R91 attempted to push through the dining room exit doors. (continued on next page)

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	175444	A. Building B. Wing	02/26/2025

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 at 10:13 AM, Certified Nurse Aide (CNA) M stated staff were expected to keep the cognitively impaired residents out of other resident's rooms. She stated staff were to provide supervision, activities, and redirection to help prevent wandering or elopement attempts. On 02/26/25 at 10:30 AM, Licensed Nurse G stated staff were expected to closely monitor wandering residents and ensure the were safe. She stated staff were expected to provide ongoing supervision to prevent potential elopement from the rear doors. On 02/26/25 at 11:30 AM, Administrative Nurse D stated the direct care staff were expected to monitor the exit doors in case they became unlocked, or the memory care residents attempt to exit. She stated the residents should not be entering other resident's room and staff were expected to redirect them from entering other rooms. The facility was unable to provide a policy related to dementia care as requested on 02/26/25. The facility failed to provide dementia-related care services for R91 to promote the resident's highest practicable level of well-being. This deficient practice placed R91 at risk for decreased quality of life, isolation, and impaired dignity.

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	175444	A. Building B. Wing	02/26/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49634 The facility identified a census of 47 residents. The sample included 12 residents, with one medication room and four medication carts. Based on observation, record review, and interviews, the facility failed to ensure controlled substances were accounted for and reconciled between shifts. This deficient practice placed the residents at risk for misappropriation and/or diversion of controlled substances. Findings included: - On 02/25/25 at 07:14 AM a review of the December 2024, January, and February 2025 Narcotic Count Sheet on the 100, 200, and 300 halls revealed a missing signature for Nurse On for the dates of 2024 were 12/22 and 12/31. The missing signatures for Nurse On for 2025 were 01/01, 01/08, 01/12, 01/13, 01/16, 01/17, 01/18, 01/19, 01/22, 01/23, 01/24, 01/27, 01/28, 01/29, 01/30, 02/19, 02/20, 02/22, and 02/23. On 02/25/25 at 07:14 PM, a review of the December 2024, January, and February 2025 Narcotic Count Sheet on the 100, 200, and 300 halls revealed a missing signature for the Nurse Off for the dates of 2024 were 12/22, 12/23, 12/25, 12/30, and 12/31. The missing signatures for Nurse Off for 2025 were 01/01, 01/02, 01/03, 01/04, 01/05, 01/06, 01/07, 01/08, 01/09, 01/10, 01/11, 01/12, 01/13, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21, 01/22, 01/24, 01/25, 01/26, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22, 02/23, and 02/24. On 02/25/24 at 07:14 AM, Certified Medication Aide (CMA) stated the facility's policy was nurses or a CMA were to count with the oncoming CMA and the off-going CMA, to ensure the narcotic count was correct. On 02/26/25 at 07:14 AM, Licensed Nurse (LN) G stated each nurse or Certified Medication Aide (CMA) was to count with the on-coming and off-going nurse daily. She stated nursing staff were not supposed to leave the facility until the narcotic count was correct. On 02/26/24 at 02:26 PM, Administrative Nurse D said she expected anyone on the medication carts to count with the oncoming nurse each shift. The facility's Medication Storage dated 04/16/24 documented that the facility was to ensure all medications housed on the premises would be stored in medication rooms or medication carts. The facility would store medications according to the manufacturer's recommendation and sufficient to ensure proper sanitation, temperature, light ventilation, moisture control, segregation, and security. All narcotics are stored under a double lock and key. Any discrepancies that cannot be resolved must be reported immediately to the Director of Nursing, charge nurse, or designee. Staff were to complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted. Nursing staff must not leave the area until discrepancies are resolved or reported as unresolved discrepancies. (continued on next page)

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	175444	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure an accurate reconciliation of controlled medications was completed. This deficient practice placed residents at risk of medication misappropriation and diversion.

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	175444	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 47 residents. The sample included 12 residents, with one medication room and four medication carts. Based on observation, record review, and interviews, the facility failed to appropriately store medications and biologicals when staff failed to ensure the tuberculin (a sterile liquid used to diagnose tuberculosis) test serum was dated after the vial was opened. This placed the residents at risk for adverse outcomes or ineffective medication regimens. Findings included: - On [DATE] at 07:51 AM, the facility's medication room refrigerator contained two vials of tuberculin test serum that were undated. The tuberculin serum was opened, and the vials were undated. On [DATE] at 07:53 AM, Licensed Nurse (LN) G stated all tuberculin should have an opened date, either on the box or on the vial. LN G was unsure how long the vial was good for after the vial was opened. LN G verified the vials of tuberculin were undated. On [DATE] at 11:23 AM, Administrative Nurse D stated the tuberculin test serum should be dated with an open date or an expired date when the vials were opened. The facility's Medication Storage policy dated [DATE] documented all medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. The pharmacy and the medication room would be routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible missing labels. These medications are destroyed in accordance with our destruction of unused drugs policy. The facility failed to ensure the tuberculin test serum was dated when the vials were opened. This placed the residents at risk for adverse outcomes or ineffective medication regimens.

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	175444	A. Building B. Wing	02/26/2025

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45668 The facility identified a census of 47 residents and one kitchen. Based on record review and interviews, the facility failed to provide the services of a full-time certified dietary manager for the 47 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 02/25/25 at 02:30 PM, Administrative Staff A reported the facility currently did not have a certified dietary manager. On 02/26/25 at 11:00 AM, Dietary Staff BB stated she had been with the facility for over a year but was not certified. She stated the dietary manager came monthly. She stated she had not started classes but was looking into them. The facility's Dietitian policy last revised 04/2024 indicated the facility was to ensure a qualified, competent, and skilled dietary manager would help oversee the food and nutrition services in the facility. The facility failed to employ a full-time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparation, and storage of food for the 47 residents in the facility. This placed the residents at risk for inadequate nutrition.

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	175444	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45668 The facility identified a census of 47 residents with one kitchen. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to storage, preparation, and meal service. This deficient practice placed the residents at risk for food-borne illnesses and food safety concerns. Findings Included: - On 02/24/25 at 07:00 AM, a walkthrough of the facility was completed. An inspection of the dining hall revealed the dining room was closed off to the residents. The dining room ceiling fixtures hung from the ceiling. Dust covered the tables and floor of the dining room. No barriers were in place between the construction area and the food preparation areas. On 02/24/25 between 07:00 AM and 04:00 PM the door between the dining room, leading directly into the kitchen's cooking area remained propped open during meal preparation for breakfast, lunch, and dinner services. The dining room was cleaned and reopened on 02/25/25 for breakfast. On 02/24/25 at 07:30 AM, an inspection of the Memory Care Unit's kitchenette revealed opened/undated ice cream in the freezer unit. On 02/24/25 at 07:09 AM, Certified Nursing Aide (CNA) N stated the dining room was closed due to the roof caving in during the recent ice storm. She stated the dining room was under construction and off-limits to the resident. On 02/25/25 at 03:39 PM, CNA OO assisted with positioning several residents for breakfast, passed several food trays out, and began to provide assistive feeding to three residents for breakfast. CNA OO failed to complete hand hygiene during the entire breakfast service or during assistive feedings. On 02/26/25 at 10:15 AM, CNA N stated staff were expected to complete hand hygiene in between assisting residents or after touching soiled surfaces. She stated hand hygiene should be completed when switching between assisting different resident's meals. CNA N stated staff were expected to check and clean out the refrigerators outside the kitchen area. On 02/26/25 at 11:06 AM, Dietary Staff BB stated staff were expected to complete hand hygiene before, during, and after assisting residents or passing meals. She stated the facility had a verbal agreement for the memory care staff to clean the refrigerator. She stated the facility was to ensure plastic was placed to prevent contamination from the dining room construction if the doors were propped open. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Food Services and Nutrition policy (undated) indicated the facility would promote a system that identified proper service, cleaning, and food storage. The policy noted all surfaces within the dining room and kitchen were to be cleaned and sanitized per professional standards. The policy indicated food would be labeled/dated and stored in a manner that is safe and maintains nutritional value. The policy indicated staff were to ensure safe food handling practices to prevent cross-contamination and food-borne illness. The policy indicated staff should complete hand hygiene in between touching surfaces related to direct food preparation, handling, and serving. The policy noted all kitchen and dining equipment would be stored in a manner that prevented soiling or contamination of clean items. The facility failed to follow sanitary dietary standards related to food storage, preparation, and meal service. This deficient practice placed the residents at risk related to food-borne illnesses and food safety concerns.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 47 residents. The sample included 12 residents, with three residents reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R) 15. This placed the resident at risk for inappropriate end-of-life care. Finding Included: - R15's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), major depressive disorder (major mood disorder that causes persistent feelings of sadness), myocardial infarction (heart attack), rhabdomyolysis (breakdown of damaged skeletal tissue), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), assistance with personal care, muscle weakness, hypertension (high blood pressure), unsteadiness of feet, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R15 was impaired on both sides of her body. The MDS documented R15 was dependent on staff for bathing and needed substantial to maximum assistance for toileting and oral hygiene. The Annual MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented R15 required assistance with set-up and clean-up for eating, bathing, and dressing. R15 required substantial to maximum assistance for toileting. R15's The Functional Abilities (Self-care and Mobility) Care Area Assessment (CAA) dated 04/09/24 documented staff would continue to assist R15 with care. R15's Care Plan dated 01/29/25 documented R15 was admitted to hospice with a terminal illness. R15's plan of care documented her symptoms would be managed by interventions throughout the end of life. Staff would assess for pain, restlessness, agitation, constipation, and other symptoms of discomfort. Staff would medicate as ordered and evaluate effectiveness. R15's plan of care documented staff would provide nonpharmacological approaches to aid in decreasing discomfort. Bereavement services would be provided by hospice and the facility staff would notify hospice of any significant changes. R15's plan of care documented staff would provide medications per hospice and physician orders. On 02/24/25 at 07:35 AM, R15 laid on her bed asleep, with her nasal cannula in place. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/25 at 08:50 AM, R15 laid on her bed asleep, with her nasal cannula in place. On 02/26/25 at 09:56 AM, Certified Nursing Aide (CNA) M stated she was unsure what hospice provided for the residents. She stated the hospice aides would let the staff know if the hospice provider left any supplies. CNA M stated the facility provided showers on opposite days of hospice. She stated the hospice aide had scheduled days to give showers. CNA M stated she did not think what supplies or equipment, nor when the aide or nurse would be in the facility were on the resident's care plan. On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated she was unsure what hospice provided. LN G stated she did not think what hospice provided would need to be on the facility's care plan, as it was on the hospice plan of care. LN G stated hospice aides and nurses were good at telling the facility what equipment and supplies they had brought to the resident. On 02/27/25 at 11:23 AM, Administrated Nurse D said she knew what supplies hospice provided were on the detailed care plan hospice provided. She stated the aides and nurses were good at reporting to staff when supplies were left and showers were given to the resident. She stated it would probably benefit the facility and the staff if the care plan was more detailed and matched the hospice providers. The facility's Coordination of Hospice Services dated 02/22/24 documented when a resident chooses to receive hospice care and services, the facility would coordinate and provide care in cooperation with hospice staff to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility and hospice provider would coordinate a plan of care and would implement the intervention according to the resident's needs, foals, and recognized standards of practice in consultation with the resident's attending physician and resident representative to the extent possible. The care plan would identify the care and services that each entity would provide to meet the needs of the resident and his expressed desire for hospice care. The facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for R15. This placed the resident at risk for inappropriate end-of-life care.

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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. 49634 The facility identified a census of 47 residents. The facility identified eight residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure the linen cart was covered, and wash clothes were not stuffed in the guard rails outside of resident's rooms, and further failed to ensure all oxygen cannulas and nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) masks were stored in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Findings included: - On 02/24/25 at 07:07 AM on the initial walk-through of the facility, wash clothes were placed in the handrails outside residents' rooms on the 100, 200, and 300 halls. On the 300 hall, the linen cart with towels, washcloths, and bedding was left uncovered. On 02/24/25 at 07:35 AM, R15's nebulizer mask laid directly on her bedside table. At the bottom of R15's bed sat an oxygen tank. The green oxygen tank sat on a stand, and a nasal cannula was wrapped around the handle. R15's nebulizer mask and nasal cannula were not stored in a sanitary manner. On 02/26/25 at 10:14 AM, Licensed Nurse (LN) G stated all respiratory equipment should be placed in an appropriate bag labeled with the resident's name when the resident was not using the equipment. LN G stated washcloths should not be stored outside residents' rooms on side rails. LN G stated the linen cart should always have the flap down. On 02/26/25 at 11:23 AM, Administrative Nurse D stated all staff were responsible for ensuring the respiratory equipment not in use was contained in a sanitary bag. Administrative Nurse D stated the linen cart should always be covered in a sanitary manner. She stated washcloths should not be on the guardrail outside residents' rooms. The facility's Oxygen Administration policy dated 01/08/24 documented oxygen was administered to residents who needed it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Staff would perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Staff would follow manufacturer recommendations for the frequency of cleaning equipment filters, and change oxygen/mask weekly and as needed. Staff were to keep delivery devices covered in plastic bags when not in use. The facility did not provide a policy for the storage of linens in a linen cart, or proper storage of washcloths. The facility failed to ensure the linen cart was covered, and wash clothes were not stuffed in the guard rails outside resident rooms. The facility further failed to ensure all oxygen cannulas and nebulizer masks were stored in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41037 The facility had a census of 47 residents. Five Certified Nurse Aides (CNA) were sampled for required in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for decreased quality of life and/or inadequate care. Findings included: - A review of the information facility's in-service records revealed the following CNAs were employed with the facility for more than 12 months: CNA O, hired 09/02/14, had not completed the required in-services in the past 12 months. CNA NN, hired 11/08/18, had not completed the required in-services in the past 12 months. CNA Q, hired 08/03/21, had not completed the required in-services in the past 12 months. CNA P, hired 03/06/23, had not completed the required in-services in the past 12 months. CNA MM, hired 04/12/23, had not completed the required in-services in the past 12 months. On 02/26/25 at 11:31 AM, Administrative Nurse D stated she was responsible for ensuring the direct care staff received their required 12 hours of in-service education. The facility's Required Training, Certification and Continuing Education of Nurse Aides policy dated 03/01/24 documented the facility would provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. The facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for decreased quality of life and/or inadequate care.