STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. Building B. Wing	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eskridge Care and Rehab	505 N. Main Street Eskridge, KS 66423

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 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40689 The facility identified a census of 57 residents, with three residents reviewed for food allergies. Based on record review, observation, and interview, the facility failed to accommodate R1's known food allergy to mushrooms which caused anaphylactic (severe life-threatening allergic reaction) allergic reaction. The facility failed to follow R1's dietary care plan, when staff served R1 facility food (oriental vegetables) for lunch, that contained mushrooms. R1 advised Certified Nurse Aide (CNA) M her mouth and throat were itching, and she was severely allergic to mushrooms. R1 required administration of diphenhydramine (antihistamine), administration of an epinephrine (adrenaline use to treat anaphylaxis) pen, and transfer by Emergency Medical Services (EMS) to the Emergency Department (ED) for evaluation and treatment. This deficient practice placed R1 in immediate jeopardy. Findings included: - The signed Physician Order Sheet (POS) for R1, dated 01/31/24, documented the facility admitted the resident on 03/24/22, with the following diagnoses: conversion disorder (a mental condition in which a person experiences blindness, paralysis or other nervous system symptoms that cannot be explained by illness or injury), asthma (disorder of narrowed airways that caused wheezing and shortness of breath), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The Annual Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident required supervision with eating. The Nutritional Status Care Area Assessment (CAA), dated 03/23/23, documented R1 could feed herself during meals and staff were to encourage the resident to eat healthy foods and snacks. The 01/27/24 Quarterly MDS documented the resident had a BIMS of 15 and required supervision with eating. The residents Altered Nutritional Status Care Plan, dated 12/30/22, included R1 had allergies to mushrooms, which were listed on her tray card. The revised care plan, dated 02/21/24, directed staff to review allergies when ordering her food tray. (continued on next page)

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

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Registered Dietician's Annual Assessment, dated 12/21/23, documented R1 was on regular diet and had an allergy to mushrooms. Review of a Nursing Note revealed on 02/16/24 at 12:53 PM the resident was eating lunch when she noticed there were mushrooms in the food, and alerted staff to her allergy of mushrooms. The resident advised staff her throat and body began to itch. Review of a Nursing Note revealed on 02/16/24 at 12:53 PM the nursing staff notified R1's Healthcare Provider (HCP) of the resident's allergies to mushrooms and she was served mushrooms at lunch. The HCP provider ordered diphenhydramine, 50 milligrams (mg), by mouth, now, and 25 mg as needed (PRN), by mouth, every four hours. Review of a Nursing Note on 02/16/24 at 12:53 PM documented nursing staff observed R1's tongue began to swell and the resident reported her throat was swelling. Nursing staff then administered an epinephrine pen solution, 0.3 milligrams/0.3 milliliters (ML), to R1's right thigh. The staff notified R1's HCP and staff received an order to transport the resident to the Emergency Department (ED) by Emergency Medical Services (EMS). On 02/22/24 at 12:13 PM, the resident sat at the dining room tablet eating lunch. On 02/22/24 at 10:12 AM, Licensed Nurse (LN) G reported the resident complained her body and throat were itching after she consumed some of her meal that contained mushrooms. Staff notified the HCP and received an order for diphenhydramine. LN G administered the diphenhydramine, which was ineffective. The resident advised LN G that her tongue and throat began to swell, and LN G administered the epinephrine. Staff notified the HCP again and received an order to transport the resident to the Emergency Department (ED) by Emergency Medical Services (EMS). On 02/22/24 at 09:28 AM, Administrative Nurse D reported that Dietary Staff BB knew R1 had an allergy to mushrooms and did not check the ingredient label of the oriental vegetables, which contained mushrooms. On 02/22/24 at 10:17 AM, Dietary BB reported on 02/16/24, staff served sweet and sour chicken with oriental vegetables for the noon meal. Dietary BB reported she was asked by nursing staff if mushrooms were in the meal. After checking the oriental vegetable bag, Dietary BB found small mushrooms in it, which she did not notice when she prepared the meal. Dietary BB stated she did not check the label prior to preparing R1's plate or offering R1 an alternate meal. Dietary BB said R1 had an allergy to mushrooms and the allergy was identified on R1's green card. The facility's Food Allergies and Intolerance Policy, revised 10/2022, documented the facility should ensure steps to prevent resident exposure to allergens. On 02/24/24 at 03:22 PM, Administrative Staff A was provided a copy of the Immediate Jeopardy template and notified the facility failed to follow R1's dietary care plan, which noted R1 had an allergy to mushrooms, to prevent an avoidable allergic reaction when staff served R1 facility food containing mushrooms, placed R1 in immediate jeopardy. The facility identified and implemented the following corrective actions immediately in response to the allergic reaction to R1, completed on 02/16/24: (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/16/24 at 01:35 PM, immediately re-educated staff on identifying allergens: ingredients checked for allergens and immediate medical intervention for the affected resident. On 02/16/24 at 03:00 PM, all residents with food allergies were identified and tray cards were updated so the allergens were more easily visualized. Dietary Manager reviewed all food supplies in the Kitchen to identify any food allergens, Dietary Manager reviewed all recipes to identify food allergens. On 02/16/24 at 04:30 PM, Quality Assurance and Performance Improvement (QAPI) meeting held. Due to the corrective actions implemented prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J score and severity.