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	02/24/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 26768 The facility had a census of 58 residents. Based on record review and interview the facility failed to provide two of three sampled residents, Resident (R)9 and R111 (or their representative) the CMS (Center for Medicaid/Medicare Services) approved Skilled Nursing Facility Advanced Beneficiary Notices (ABN) form 10055. The facility failed to provide R9 and R111 the contact phone numbers on the Notice of Medicare Non-Coverage (NOMNC) Form-10123 which informed the beneficiary of the right to an expedited review by a Quality Improvement Organization (QIO). This placed the residents at risk of uninformed decisions about their skilled services. Findings included: - Review of the Notice of Medicare Non-Coverage (NOMNC) document on Form CMS 10123-NOMNC informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included directions for the beneficiary (resident or resident representative) to contact the QIO for questions regarding appeals. Review of R9's NOMNC revealed Medicare Part A skilled services ended on 01/12/25. The facility provided CMS Form 10123 which lacked QIO name and contact number information for R9. The ABN form was completed but not the CMS approved form 10055. Review of R111's NOMNC revealed Medicare Part A skilled services ended on 01/21/25. The facility provided CMS Form 10123 which lacked QIO name and contact number information for R111. The ABN form was completed but not the CMS approved form 10055. On 02/20/25 at 10:24 AM, Administrative Nurse E verified she had not written the QIO phone number on the 10123 form and had not used the 10055 ABN form for R9 and R111's Part A discharge. The facility's Beneficiary Notice policy, dated 08/2024, stated a Medicare beneficiary had the right to have Medicare make the decision to determine if skilled services would be covered by Medicare. The facility must give notice to the beneficiary at least three days prior to termination of all Part A covered services when the beneficiary still has days left in the benefit period. The Notice of Medicare Non-Coverage, form 10123, informs the beneficiary how to request an expedited redetermination from QIO (Quality Improvement Organization) and provided the phone contact number. The policy directed staff to prepare and issue CMS form 10055 (Advanced Beneficiary Notice) to the resident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Eskridge Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. Main Street Eskridge, KS 66423	

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide R9 and R111 the QIO contact number for appealing Medicare Part A decisions and the CMS approved 10055 ABN form. This placed R9 and R111 at risk of uninformed decisions about their skilled services.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 58 residents. The sample included 16 residents, with two reviewed for discharge from the facility to an acute care hospital. Based on observation, interview, and record review the facility failed to notify the Long-Term Care Ombudsman (LTCO - a public official who works to resolve resident issues in nursing facilities) of the discharges for Resident(R) 26 and R111. This placed the two residents at risk for uninformed care choices. Findings included: - R26's Electronic Medical Record (EMR) documented diagnoses of bipolar type (episodes of severe high and low moods) schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), chronic tension-type headache, and posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). R26's Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R26 required staff set up for all activities of daily living (ADL), had frequent, moderate pain, and used tobacco products. R26's EMR documented she was hospitalized from 12/29/24 to 12/31/24. The facility lacked proof they had sent a notice to the ombudsman regarding R26's discharge to the hospital. On 02/24/25 at 10:20 AM, R26 walked past other residents and staff and stated she was not fine, and wanted to get out of here. On 02/24/25 at 10:45 AM, Social Services Staff X stated the facility only sent a Continuation of Stay form to the KDADS offices monthly, listing all residents and if they were still in the facility or had moved somewhere else. She stated the facility did not have an ombudsman and did not send information to them regarding hospitalization s. The facility's Transfer or Discharge policy, dated 08/2024, stated the resident or their representative would be provided a written notice with the reason for the discharge or transfer and sent a copy of the notice to the office of the LTCO. The facility failed to send a notice to the LTCO office regarding R26's discharge to the hospital, placing R26 at risk for uninformed decision making. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R111's Electronic Medical Record (EMR) documented diagnoses of Schizoaffective Disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and Chronic Obstructive Pulmonary Disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R111 had long-term memory problems, moderately impaired decision-making skills, and an acute mental status change. The MDS documented R111 had delusions, abnormal behaviors, and was dependent on staff for all activities of daily living. R111's EMR documented she was hospitalized from 01/29/25 to 02/19/25. On 02/19/25 at 02:25 PM, Emergency Medical Services (EMS) brought the resident back to the facility to her room. R111's family accompanied her, and Licensed Nurse (LN) G assessed R111. On 02/24/25 at 10:45 AM, Social Services Staff X stated the facility only sent a Continuation of Stay form to the KDADS offices monthly, listing all residents and if they were still in the facility or had moved somewhere else. She stated the facility did not have an ombudsman and did not send information to them regarding hospitalization s. The facility's Transfer or Discharge policy, dated 08/2024, stated the resident or their representative would be provided a written notice with the reason for the discharge or transfer and sent a copy of the notice to the office of the LTCO. The facility failed to send a notice to the LTCO office regarding R111's discharge to the hospital, placing R111 at risk for uninformed decision making.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 58 residents, and the sample included 16 residents. Based on observation, record review, and interview, the facility failed to assess and maintain urine continence for Resident (R) 51. This deficient practice placed R51 at risk of embarrassment and complications from incontinence. Findings included: - R51 ' s Electronic Medical Record (EMR) included diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar type (a major mental illness that causes people to have episodes of severe high and low moods), autistic (a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication) disorder, insomnia (inability to sleep) due to other mental disorders, extrapyramidal (movement disorders as a result of taking certain medications) and movement disorder, constipation (difficulty passing stools), and encopresis (repeated passing of stool usually involuntary into clothing) not due to a substance or known physiological condition. The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R51 had intact cognition, fluctuating inattention, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and no exhibited behaviors. R51 required setup or clean-up assistance with toileting, showering, upper and lower body dressing, and mobility. The MDS further documented that R51 was always continent of urine and bowels. The Quarterly MDS, dated [DATE], documented R51 had intact cognition, fluctuated disorganized thinking, delusions, and other behavioral symptoms not directed toward others which occurred one to three days of the seven-day look-back period. R51 required setup or clean-up assistance with toileting, showering, upper and lower body dressing, and mobility. The MDS further documented that R51 was occasionally incontinent of urine with no trial of a toileting program or current toileting, and always continent of bowel. The admission Urinary Incontinence Care Area Assessment (CAA), dated 03/15/24, documented R51 had the potential for a decline in toileting hygiene. The resident is encouraged to be as independent as possible. The CAA further documented R51 was up ad lib (as desired) with a steady gait. R51 ' s Care Plan dated 02/20/24, documented R51 had a diagnosis of encopresis related to constipation related to psychotropic (alters mood or thought) medication use. The care plan instructed staff to observe patterns of incontinence and initiate a toileting schedule if indicated, offer the use of briefs, and provide peri-care items for cleaning himself up following incontinent episodes. The Quarterly Nursing Evaluation Progress Note dated 11/21/24 at 03:03 PM, documented no new urinary incontinence. (continued on next page)

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Eskridge Care and Rehab	505 N. Main Street Eskridge, KS 66423

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 30-day (01/23/25 to 02/22/25) bladder continency review revealed R51 had incontinence 18 days during a 30-day look-back period. On 02/19/24 at 08:30 AM, R51 carried a large clear plastic bag of linens down the hall. R51 ' s bed had a large wet area in the center of the bed. On 02/24/25 at 07:52 AM, Certified Nurse Aide (CNA) O reported R51 had some incontinence, and staff at times told him he needed to change his clothes. CNA O stated that R51 would ask staff for linens. On 02/24/24 at 12:12 PM, Administrative Nurse E reported the nurse aides observed for incontinence and documented in the EMR which populated the MDS. Administrative Nurse E stated R51 ' s incontinence was usually nocturnal and would have the physician review medication to see if that may be causation due to sleeping through the urge or the need to void. Administrative Nurse E stated staff should have the resident on a night toilet regimen. On 02/24/25 at 02:15 PM, Administrative Nurse D stated that R51 ' s incontinence should be assessed to determine possible causation factors. The facility ' s Urinary Continence and Incontinence Assessment and Management policy, dated 10/2024, documented the facility must ensure that a resident who is continent of bladder and bowel on admission receives care and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. The facility failed to assess causation factors and maintain R51 ' s urinary incontinence. This deficient practice placed the resident at risk for continued embarrassment and complications of urinary incontinence.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 58 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to address Resident (R) 51's food preferences and dislikes with continued weight loss resulting in a significant weight loss of 11.3 percent (%) in six months. Findings included: - R51's Electronic Medical Record (EMR) included diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar type (a major mental illness that causes people to have episodes of severe high and low moods), autistic (a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication) disorder, insomnia (inability to sleep) due to other mental disorders, extrapyramidal (movement disorders as a result of taking certain medications) and movement disorder, constipation (difficulty passing stools), and encopresis (repeated passing of stool usually involuntary into clothing) not due to a substance or known physiological condition. The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R51 had intact cognition, fluctuating inattention, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and no exhibited behaviors. R51 required setup or clean-up assistance with toileting, showering, upper and lower body dressing, and mobility. The MDS further documented R51 weighed 165 pounds (lbs.), had weight loss, and not on a prescribed weight loss regimen. R51 had no swallowing disorder and received a mechanically altered diet. The Quarterly MDS, dated [DATE], documented R51 had intact cognition, fluctuated disorganized thinking, delusions, and other behavioral symptoms not directed toward others which occurred one to three days of the seven-day look back period. R51 required setup or clean-up assistance with toileting, showering, upper and lower body dressing, and mobility. The MDS further documented that R51 weighed 159 lbs, had unknown weight loss or gain, no swallowing disorder and lacked nutritional approaches. The Admission Nutrition Status Care Area Assessment (CAA), dated 03/15/24, documented R51 had the potential for nutritional problems related to low body mass index (BMI), recent weight loss since admission. The resident was edentulous, received a mechanical soft diet, and reported being a picky eater at times. The CAA further documented R51 was offered snacks between lunch and dinner and evening snack prior to bed. The assessment lacked food likes and dislikes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's Care Plan dated 12/18/24, documented R51 at risk for altered nutritional/hydration status related to decreased fluid need due to hyponatremia, edentulous, inadequate intake, and weight loss. The care plan directed staff to honor food preferences and update as needed. R51 was a very picky eater and to remind him about the alternative meal, but to respect his right to refuse. The care plan further documented R51 receive a magic cup (frozen nutritional supplement) one time a day at lunch most generally, please offer it to the resident after he eaten his meal. R51 liked to sleep in and would sometimes refuse breakfast. The staff were to monitor and record meal intake, offer snacks between meals and as desired, and the Registered Dietician (RD) would evaluate and make recommendations and to weigh R51 monthly. The care plan lacked specific food preferences. Record Review of R51 weights revealed: On 02/08/24 admission weighed of 176.0 lbs. On 03/04/24 weighed 165.0 lbs. (a significant weight loss of 6.25% in a 30 day review from 02/08/24 to 03/04/24). On 06/03/24 weighed 162.8 lbs On 08/05/24 weighed 165.0 lbs. On 10/07/24 weighted 158.6 lbs. On 01/07/25 weighed 158.2 lbs. On 02/19/25 weighed 153.0 lbs. R51's EMR 30 day (01/22/25 to 02/20/25) meal intake review revealed R51 had refused the breakfast meal 17 times and the lunch meal three times and the supper meal once. The Progress Note dated 03/04/24 at 10:39 AM, documented a five percent weight loss variance over 30 days. The Progress Note dated 04/10/24 at 05:43 PM, documented R51 was a patient at risk related to weight loss. Both dietary and nursing contributing factor of weight loss due to R51 stated he does not want to eat some of the food. R51 preferred peanut butter and jelly sandwich most meals. The Progress Note dated 05/01/24 at 09:49 PM, documented R51's physician ordered twice a week weight related to weight loss. R51 was to receive his preferences at mealtime to reduce further weight loss. The Progress Note dated 05/07/24 at 08:53 AM, documented a nutrition review was completed for R51. R51 diet order is fortified foods, mechanical soft, ground meat texture. The meal intakes were fair ranging 51 to 75% intake in the last eleven days. R51 was currently receiving supplements. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 05/14/24 at 11:01 AM, documented staff talked to R51 about weight loss and food intake. R51 stated he does not feel that the food was appealing to him but agreed to have a med pass at 10:00 AM and 2:00 PM for a nutrition supplement. Staff educated reason risks and benefits of proper nutrition. The Progress Note dated 06/05/24 at 11:09 AM, documented a nutritional assessment had been completed. R51 had gradual weight loss of the past six month. R51 received fortified foods, snacks, and magic cup. R51's current intake was not adequate to maintain his estimated needs. The note documented recommendation to discontinue fortified foods and magic cup, and instead would offer six ounces of Med Pass supplement if R51 refused a meal. The Progress Note dated 08/03/24 at 02:56 AM, documented R51 had a swallow study and received new order for a regular diet. The Progress Note dated 10/11/24 at 03:31 PM, documented a nutritional assessment was completed. The RD spoke with R51 and informed him of his weight loss and dropped below weight goal. R51 agreed to Magic Cup three times a day with meals. New goal weight of 158 lbs. The Progress Note dated 12/02/24 at 01:37 PM, documented R51 received a therapeutic regular diet, meal intake was fair averaging 51 to 75%. R51 received supplements and was on a fluid restriction. The Progress Note dated 02/06/25 at 02:07 PM, documented a nutritional review. R51 had not had a significant weight loss in the last month or last six months. On 02/19/25 at 03:25 PM, R51 came to the facility's conference room, drinking a supplement drink while talking with the survey team. R51 talked in a very quiet voice. R51 reported he had not gotten many of the supplement drinks but liked them and voiced he needed to put on weight. On 02/24/25 at 07:52 AM, Certified Nurse Aide (CNA) O reported R51 slept late and sometimes he ate a whole meal and other times would just eat a few bites. On 02/24/25 at 08:38 AM, Dietary Staff (DS) BB reported she was unsure of R51's total weight loss and would have to review the clinical record to determine if it was significant. DS BB stated when a resident admitted to the facility a food preference was completed on admission. DS BB stated she had not talked to R51 on food preferences. Upon record review preferences were not found. DS BB reported R51 got chicken broth with lunch and a magic cup daily, he could not sit for long periods of time in the dining room and got up and would throw away his meal, but then come back later and ask for dessert or a magic cup. On 02/24/25 at 09:50 AM, R51 stated he was aware of weight loss since admission. He reported being a picky eater but liked pizza, hot dogs, hamburgers, and tacos. He reported he did not like chicken due to past experience of working on a chicken farm when a roof collapsed and killed thousands of chickens that he had to clean up, therefor that turned him off of chicken. 02/24/25 at 02:15 PM, Administrative Nurse D stated she would expect someone on staff to have talked to R51 about his weight loss and food preferences to prevent further weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Nutritional Assessment policy, dated 10/2024, documented a nutritional assessment including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. Nursing and the Interdisciplinary Team (IDT) to include food preferences and dislikes. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's prognosis and personal preference. The facility failed to assess R51's preferences of diet to address continued weight loss. This deficient practice placed R51 at risk for continued significant weight loss.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 58 residents. The sample included 16 residents, with two reviewed for side rails. Based on observation, record review, and interview, the facility failed to assess the actual rail being used to assure safety for Resident (R) 7 and R1. This placed the residents at risk for accident or injury due to unidentified risks associated with side rail use. Findings included: - R7's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and tremors. R7's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS documented R7 required substantial to maximum assistance with bed mobility and transfers. The MDS lacked documentation the resident had side rails. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/27/24, recorded R7 had trouble finding words and expressing herself, and recognized her surroundings, but could be forgetful. The Activities of Daily Living (ADL) CAA, dated 06/27/24, recorded staff transferred R7 per total body left and had a non-weight bearing status. R7's Care Plan, dated 12/03/24, documented R7 required extensive assistance with daily needs and propelled herself in a wheelchair around the facility. The care plan documented the resident utilized grab bars on the bed for safety and mobility. The care plan documented the resident used the grab bars for rolling from side to side while in bed, slide herself up and down in the bed, and support herself. R7's EMR recorded a Side Rail Evaluation completed on 01/28/25 documenting the resident used the rails to pull or push herself for mobility. The assessment documented alternatives to bed rails attempted were roll guards, a low bed to the floor, a concave mattress, and the alternatives had failed. On 02/20/25 at 08:25 AM, observation revealed a half-circle side rail on the upper right and left side of R7's bed with an opening approximately 13 inches wide by 20 inches high. Continued observation and examination revealed the side rail had a piece of canvas material covering 1/2 of the height of the rail, however, it was torn and easily movable to allow for a larger opening. The rail was unstable, able to be moved up and down, and back and forth a few inches with slight pressure on the rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/24/25 at 10:00 AM, Administrative Nurse D verified the bed rails on R7's bed had too large of an opening, and the rails were not stable and were able to be moved easily. Administrative Nurse E verified the facility lacked any further assessment for the use of the side rail. The Bed Safety-Bed Rails policy, dated 10/2024, documented the facility strived to provide a safe sleeping environment for the resident. Upon admission, evaluate the current status of the resident for any type of bed rail. Prior to applying any type of rail, attempt an alternative such as a roll guard, foam bumper, concave mattress, or lower the bed to the floor. The policy documented after attempted alternatives failed to complete the bed rail evaluation, including risk, upon admission, quarterly, and change of need or condition. Prior to applying the bed rail, obtain consent to include, the medical need for the rails, the benefit for use of the bed rails, how the risk would be mitigated, alternatives attempted but failed to meet the resident's needs, and alternatives considered but not attempted that were considered inappropriate. Staff would obtain a physician's order for the use of the bed rails. The bed rails would be used if assessment and consultation with the Attending Physician had determined they were needed to help manage a medical symptom or condition or to help the resident reposition, move in bed, and transfer, and no other reasonable alternative could be identified. The bed rails would be applied per manufacturer instructions and specifications for compatibility with the bed frame and mattress requirements. The facility was directed to confirm the rails are installed with the appropriate size and weight of the resident and to inspect regularly. The policy documented that staff would add the type of bed rails to the resident's care plan, including what type of specific direct monitoring and supervision would be provided during the use of the bed rails and where it would be documented. The policy directed identification of how needs would be met during the use of the side rail, such as turning and repositioning, and how often the use of the rails would be assessed, including evaluation if they need to be discontinued. Ongoing evaluation and risks, and any additional interventions to address residual effects of the bed rail use. The facility failed to adequately assess R7's actual rail in use to ensure safe openings and failed to assess for the safe use of a side rail prior to placing the side rail on R7's bed. This placed her at risk for accident or injury due to unidentified risks associated with side rail use. - R1's Electronic Medical Record (EMR) recorded diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) dementia (a progressive mental disorder characterized by failing memory and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R1's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R1 required substantial to maximum assistance with bed mobility and transfers. The MDS lacked documentation the resident had side rails. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 10/07/24, recorded R1 had the potential for a decline in her cognition due to the diagnosis of dementia and potential further memory loss. The CAA documented the resident could be confused and forgetful. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Eskridge Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. Main Street Eskridge, KS 66423	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Activities of Daily Living (ADL) CAA, dated 10/07/24, recorded R1 documented the resident had the potential for falls due to weakness, unsteady gait, and history of falls. The CAA documented the resident utilized a wheelchair for mobility and was able to self-propel. The CAA documented that the resident utilized grab bars on the bed to stand and pivot transfer. R1's Care Plan, dated 12/12/24, documented R1 was full weight bearing on both legs as tolerated, however chooses to use a wheelchair for mobility. The resident is at risk for falls secondary to Parkinson's, unsteady gait, and a history of falls. Staff assisted the resident with transfers due to a non-injury fall on 03/26/24 and placed a grab bar on the resident's bed. The care plan documented the resident had a fall out of bed on 12/13/24 and sustained a bruise to her right shoulder. R1's EMR recorded a Side Rail Evaluation completed on 01/28/25 documented the resident used the rails to pull or push R1's self for mobility. The assessment documented no alternatives to bed rails had been attempted and the bed rails potential risks were addressed with a representative including dignity and isolation. On 02/20/25 at 08:25 AM, observation revealed a half-circle side rail on the upper left side of R1's bed with an opening approximately 13 inches wide and 20 inches high. Continued observation and examination revealed the side rail had a piece of canvas material covering 1/2 of the height of the rail, was easily movable to allow for a larger opening, and the rail was unstable and able to be moved up and down and back and forth a few inches with pressure exerted on the rail. On 02/24/25 at 10:00 AM, Administrative Nurse E verified the bed rail on R1's bed had too large of an opening, and the rail was not stable. Administrative Nurse E verified the facility lacked any further assessment for the use of the side rail. The Bed Safety-Bed Rails policy, dated 10/2024, documented the facility strived to provide a safe sleeping environment for the resident. Upon admission, evaluate the current status of the resident for any type of bed rail. Prior to applying any type of rail, attempt an alternative such as a roll guard, foam bumper, concave mattress, or lower the bed to the floor. The policy was documented after attempted alternatives failed to complete the bed rail evaluation, including risk, upon admission, quarterly, and change of need or condition. Prior to applying the bed rail, obtain consent to include, the medical need of the rails, the benefit of use of the bed rails, how the risk would be mitigated, alternatives attempted but failed to meet the resident's needs, and alternatives considered but not attempted that were considered inappropriate. Staff would obtain a physician's order for the use of the bed rails. The bed rails would be used if assessment and consultation with the Attending Physician had determined they were needed to help manage a medical symptom or condition or to help the resident reposition, move in bed, and transfer, and no other reasonable alternative could be identified. The bed rails would be applied per manufacturer instructions and specifications for compatibility with the bed frame and mattress requirements. The facility was directed to confirm the rails are installed with the appropriate size and weight of the resident and to inspect regularly. The policy documented that staff would add the type of bed rails to the resident's care plan, including what type of specific direct monitoring and supervision would be provided during the use of the bed rails and where it would be documented. The policy directed identification of how needs would be met during the use of the side rail, such as turning and repositioning, and how often the use of the rails would be assessed, including evaluation if they need to be discontinued. Ongoing evaluation and risks, and any additional interventions to address residual effects of the bed rail use. (continued on next page)

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	175455	A. Building B. Wing	02/24/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to adequately assess R1's actual rail in use to ensure safe openings and failed to assess for safe use of a side rail prior to placing on R1's bed. This deficient practice placed her at risk for accident or injury due to unidentified risks associated with side rail use.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 37450 The facility had a census of 58 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure the required annual performance review was completed for two of the five staff reviewed. This deficient practice placed the residents at risk of receiving impaired care. Findings included: - A review of the facility nurse aide performance evaluation revealed two Certified Nurse Aides (CNA) M and CNA N who had been employed for over a year lacked an annual review. On 02/20/25 at 02:51 PM, Administrative Nurse D reported two of the five staff randomly selected staff for review lacked annual performance evaluation. The facility's Staff Competency policy, dated 06/2024, documented nursing staff would demonstrate competency in skills and techniques necessary to care for the resident's needs, as identified through resident assessments and resulting in plans of care. The premises of the competency-based program included an evaluation of a current program to identify needs and opportunities. The facility failed to ensure a nurse aide performance review related to the special needs of the resident population as identified from the facility assessment based on the outcome of the review. This deficient practice placed the residents at risk of receiving impaired care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37450 The facility had a census of 58 residents. The sample included 16 residents. Based on observation and interview, the facility failed to ensure the correct use of a subcutaneous (beneath the skin) injection of insulin (a hormone that lowers the level of glucose in the blood) during the observation of administration. This placed the resident at risk of receiving less than the ordered dose. Findings included: - On 02/24/25 at 11:48 AM, Licensed Nurse (LN) H pulled Resident (R) 7 into the quiet room for the administration of subcutaneous insulin. LN H had dialed the Novolog insulin pen to five units. LN H then injected the insulin into R7's lower left abdomen. LN H stated she usually primed the insulin with two units of waste insulin before administration but was nervous and failed to at this time. On 02/24/25 at 02:15 PM, Administrative Nurse D stated she had expected LN H to prime the insulin needle with waste insulin before administering the dose. The facility's Insulin Administration policy, dated 10/2024, documented the nursing staff would have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) before their use. The facility failed to ensure the correct use of subcutaneous injection of insulin which placed the resident at risk of receiving less than ordered insulin.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 27168 The facility had a census of 58 residents. The sample included 16 residents. Based on observation, interview, and record review, the facility failed to label Resident (R) 7, R12, and R23s' insulin (a hormone that lowers the level of glucose in the blood) flex pens with the date opened and the discard date on the two nurse medication carts. This deficient practice placed the affected residents at risk for ineffective medications. Findings included: - On [DATE] at 08:50 AM, observation of the facility's treatment cart revealed the following: R7's Novolog (rapid-acting insulin) flex pen was not labeled with an open or expired date. R12's Basaglar (long-acting insulin) flex pen was not labeled with an open or expired date. R23's Basaglar flex pen was not labeled with an open or expired date. On [DATE] at 09:00 AM, License Nurse (LN) G verified the nurses should label and date the insulin flex pens with the date opened and the expiration date. On [DATE] at 01:30 PM, Administrative Nurse D verified the nurses should label and date the flex pens with the date opened and the expiration date. Medlineplus.gov directs open, unrefrigerated Lantus (Novolog and Basaglar) can be used within 28 days; after that time, they must be discarded. The facility's Storage of Medication policy, dated [DATE], documented the facility would store all drugs and biologicals in a safe, secure, and orderly manner. The facility would not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. The facility failed to date the insulin flex pens when opened and the expiration date. This deficient practice placed the residents at risk for ineffective medication.

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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. 37450 The facility had a census of 58 residents. The sample included 16 residents. Based on observation and interview, the facility failed to store, prepare, and serve food at the required serving temperature. This deficient practice placed the residents at risk of unpalatable food and food-borne illness. Findings included: - On 02/20/25 at 11:43 AM, Dietary Staff (DS) CC prepared to serve the noon meal. DS BB took the serving temperature check which revealed the pureed turkey temperature of 110 degrees Fahrenheit (F) and the pureed corn of 115 degrees F. DS CC reported he did not know what the holding/serving temperature of the hot food was. The surveyor brought the incorrect temperatures to the kitchen supervisor for the day Social Service Staff X prior to letting the pureed turkey and corn be served. Social Service Staff X, explained to DS CC the pureed turkey and corn had to be heated to the proper temperature before serving. DS BB placed the pureed turkey and corn back into the oven. Once the pureed turkey and corn reached 160 degrees F., they were placed on the steam table for serving. On 02/24/25 at 08:22 AM, DS BB reported DS CC was a fairly new employee, still learning the job and DS BB would educate DS CC on the proper safe serving temperatures. The facility's Food Safety Requirements policy, dated 10/2024, documented that foods shall be received and stored in a manner that complies with safe food handling practices. The policy lacked the holding/serving temperature. The facility failed to store, prepare, and serve food at the required temperature. This deficient practice placed the residents at risk of unpalatable food and food-borne illnesses.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 26768 The facility had a census of 58 residents. Based on record review and interview, the facility failed to retain evidence of the required Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) members attended meetings at least quarterly, which placed residents at risk of unidentified quality care services. This placed the residents who resided in the facility at risk for decreased quality of care. Findings included: - Upon request, the facility failed to provide the facility's Quality Assurance Performance Improvement (QAPI) meeting attendance sheets for the past year. On 02/24/25 at 01:30 PM, Administrative Staff A stated the facility could not find QAA or QAPI meeting sign-in sheets from 2024. The facility's QAPI Committee policy, dated 10/2024, stated the primary goals of the QAA committee were to oversee facility systems and processes related to improving quality of care and services. The policy stated the required committee members included the Director of Nursing, the Medical Director or his/her designee, the Infection Preventionist, and at least three other staff. The policy stated the committee would meet monthly and would maintain records including the names of committee members present and absent. The facility failed to retain evidence the required QAA and QAPI members attended meetings at least quarterly. This deficient practice placed residents at risk of unidentified quality care services.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 27168 The facility had a census of 58 residents. Based on record review and interview, the facility failed to ensure the staff member designated as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program, completed the specialized training in infection prevention and control. This deficient practice placed the residents at risk for lack of identification and treatment of infections. Findings included: - On 02/20/25 at 10:00 AM, Administrative Nurse D stated she was responsible for the Infection Prevention and Control Program but lacked certification as an Infection Preventionist. Administrative Nurse D stated an Infection Preventionist was starting at the facility in a week, but presently she assumed the job and lacked certification. The Infection Preventionist policy dated 08/2024, documented the Infection Control Preventionist was responsible for assessing, implementing, developing, and monitoring the infection prevention and control program, coordinating the implementation and updating of the established infection control policies and practices. The Infection Preventionist would develop and monitor the facility's established infection control policies and practices. The Infection Preventionist would report information related to compliance with the facility's established infection control policies and practices to the Administrator and Quality Assurance and Assessment Committee. The Infection Preventionist would keep abreast of changes in infection control guidelines and regulations to maintain and update the facility's protocols, as needed, and remain current and aid in the prevention and control of the spread of infections. The Infection Preventionist would collect, analyze, and provide infection data and trends to nursing staff and health care practitioners. The Infection Preventionist would consult on infection risk assessment and prevention control strategies, and collaborate with the Administrator, Medical Director, Consulting Pharmacist, and Nursing Leadership for all things Infection Prevention, including the Antibiotic Stewardship Program. The Infection Preventionist would provide education and training and implement evidenced-based infection control practices. The Infection Control Preventionist is recommended to have a background in nursing, medical technology, microbiology, epidemiology, or another related field. The facility failed to ensure the person designated as the Infection Preventionist completed the required certification. This deficient practice placed the residents at risk for lack of identification and treatment of infections.