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	04/22/2026

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 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. Based on observation, interview, and record review, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food borne bacteria.Findings included:- During an initial tour of the kitchen on 04/20/26 at 07:41 AM, the following areas of concern were noted:1. The door handles of the oven had food debris.2. The can rack holding one-gallon cans had a build-up of food debris on the runners.3. The bottom shelf of the preparation table had a build-up of food debris.4. A three-drawered plastic storage container had a build-up of dried-on liquids and a white substance.5. The cart holding the facility ice chest had a scattered white substance and dried-on fluids.6. A one-half box of 12 X 12 dinner napkins (approximately 600 napkins) rested directly on the floor.7. A 25-pound (lb.) box of baking potatoes rested directly on the floor.8. A 20 lb. roll of ground beef was in a water bath of warm water thawing.On 04/21/26 at 10:31 AM, Dietary Staff BB confirmed the noted areas were in need of cleaning. The facility policy for Sanitation, effective 10/2025, included: The food service area shall be maintained in a clean and sanitary manner. The policy lacked instruction regarding the thawing of meat and items being stored directly on the floor.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interviews, the facility failed to provide a clean, home-like environment for the residents who resided in the facility.Findings included:- On 04/20/26 at 07:45 AM, a walkthrough of the facility revealed Resident (R) 1 had baseboard missing from the East wall of his room and R8 had baseboard missing from the [NAME] side wall of her room. Both rooms had exposed drywall, with broken drywall on the residents' floor. The gold-colored ceiling fan in the common area was covered with a lot of dust on all fan blades.On 04/22/26 at 08:50 AM, Administrative Staff A stated the facility had been remodeling in the 100 Halls. She stated there were rooms in which the baseboard was missing and said she would have the maintenance staff put the baseboard on. Administrative Staff A stated there were areas in the facility that needed work, but the facility had a budget so they worked in areas every month as they would get funds. She stated she did not realize the fan in the TV area had accumulated dust. She stated she would talk to housekeeping as housekeeping did have a deep cleaning schedule.The facility's Safe, Clean, Comfortable, Home like Environment, dated 10/25, documented residents had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Residents were encouraged to use their own belongings to the best extent possible, as such a homelike environment would be encouraged.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide Resident (R)5 with a dignified existence by not calling her by the name she wished to be called.Findings included:- R5's Electronic Medical Record (EMR) documented a diagnosis of schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) disorder.R5's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. She had hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) during the assessment period.R5's Behavioral Symptoms Care Area Assessment (CAA), dated 10/27/25, documented she had the potential for behaviors related to mental health diagnosis of schizoaffective disorder.R5's Quarterly MDS, dated [DATE], documented she had a BIMS score of 14, indicating intact cognition. She had hallucinations and delusions during the assessment period.R5's Care Plan, revised 03/31/26, instructed staff to use the resident's preferred name.On 04/20/26 at 08:44 AM, Dietary Staff CC approached R5 while she sat at the dining room table and greeted her by her legal name, not the name R5 preferred as listed on her plan of care. R5 informed Dietary Staff CC she wanted to be called by her preferred name (as listed on the care plan). Dietary Staff CC walked away from the table without using the resident's preferred name.On 04/21/26 at 08:31 AM, Certified Nurse Aide (CNA) M approached R5 while she sat at the dining room table and referred to R5 by her legal name. R5 stated she wanted to be called by her preferred name (as listed on the care plan). CNA M walked away from the table without using the resident's preferred name.On 04/21/26 at 07:11 AM, Dietary Staff CC stated staff call R5 by her legal name, but she preferred to be called by her chosen name (as listed on the care plan).On 04/21/26 at 08:07 AM, CNA M stated R5 preferred to be called by her preferred name (as listed on the care plan), but staff were directed to call her by her legal name.On 04/22/26 at 10:50 AM, CNA P stated R5's Care Plan instructed staff to refer to R5 by her preferred name and R5 was more cooperative with staff when they did use her preferred name, but most staff called R5 by her legal name. On 04/21/26 at 08:20 AM, Licensed Nurse (LN) G stated R5 had delusions such as not knowing her name. R5 would tell her staff her name was her preferred name (as listed on the care plan), which was not her legal name. LN G stated when the resident would not respond to her legal name, she would not use any name when communicating with her.On 04/22/26 at 11:07 AM, LN H stated she used R5's legal name when she spoke to R5. LN H confirmed R5's Care Plan instructed staff to use her preferred name.On 04/22/26 at 11:19 AM, Administrative Nurse D stated she referred to R5 by her legal name due to forgetting R5 used her preferred name (as listed on the care plan).The facility policy for Resident Rights, effective 11/2025, included: Our facility will make every effort to assist each resident in exercising his/her rights to ensure that the resident is always treated with respect, kindness, and dignity.

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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** Based on observation, interview and record review the facility failed to provide adequate activity of daily living (ADL) assistance for Resident (R) 40, regarding appropriate positioning while in her wheelchair, and R 50 for failure to assist with urinary incontinence.Findings included:1. R40's Electronic Medical Record (EMR) documented a diagnosis of autism (a developmental and neurological condition that affects how individuals interact, communicate, learn, and behave).R40's Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. R40 was dependent on staff for wheelchair mobility.R40's Activity of Daily Living (ADL) Care Area Assessment, dated 06/12/25, did not trigger.R40's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. R40 was dependent on staff for wheelchair mobility.R40's Care Plan, revised 03/24/26, documented the resident was dependent on staff for all ADLs related to severe cognitive impairment.R40's EMR under the Task tab, from 03/23/26 to 04/20/26 (28 days), documented R40 was dependent on staff for mobility in her wheelchair.On 04/20/26 at 08:39 AM, R40 sat in her wheelchair at the dining room table. Her bilateral feet dangled several inches above the floor. The wheelchair lacked footrests.On 04/20/26 at 12:41 PM, R40 sat in her wheelchair at the dining room table. Her bilateral feet dangled several inches above the floor. The wheelchair lacked footrests.On 04/21/26 at 08:30 AM, R40 sat in her wheelchair at the dining room table. Her wheelchair had footrests in place, and her feet dangled approximately three inches above the footrests.On 04/21/26 at 08:41 AM, Certified Nurse Aide (CNA) N stated R40's feet did not reach the floor when she was in her wheelchair because the wheelchair was too tall for her. CNA N stated the footrests to the wheelchair were underneath R40's bed but staff did not use them.On 04/21/26 at 08:41 AM, CNA M confirmed the resident's feet did not reach the floor when in her wheelchair because the cushion in her wheelchair was too thick.On 04/21/26 at 08:20 AM, Licensed Nurse (LN) G stated staff did not use footrests on the resident's wheelchair because staff will ambulate with R40 at times.On 04/22/26 at 11:07 AM, LN H stated the staff should have footrests on R40's wheelchair when they propel her.On 04/22/26 at 11:19 AM, Administrative Nurse D stated R40's feet did not reach the footrests of her wheelchair because the footrests legs were too long and did not work well for R40. Administrative Nurse D confirmed R40's feet dangled above the footrests when she was in her wheelchair.2. R50's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of repeated falls, dementia (a progressive mental disorder characterized by failing memory and confusion), abnormalities of gait and mobility, difficulty walking, muscle wasting and atrophy (wasting or decreasing in size of a part of the body), need for assistance with personal care, and lack of coordination.The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R50 had bilateral lower extremity limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R50 required substantial to maximum staff assistance for toileting and lower body dressing.R50's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 07/18/25, documented he had the potential for decline in the activities of daily living (ADLs). R50 also would have day-to-day fluctuation in the ability to perform his ADLs, and staff would assist him as needed. The CAA documented R50 had short term memory and staff were unable to educate him.R50's Care Plan, documented the following interventions:09/02/25, staff would cue and encourage him to allow assistance with ADLs, related to his decline. R50 required the assistance of one person for toileting.02/16/26, R50 required assistance for transfers.Staff would assist with applying incontinence chucks to the bed as allowed.Staff would encourage him to change after an incontinent episode, because he did not always realize when incontinent episode had occurred.03/31/26 staff would cue him to use the bathroom to reduce some incontinence episodes.On 04/20/2026 at 09:12 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, R50 sat in his wheelchair in front of the nurse's desk with visibly wet navy pants and blue checkered. R50 asked several staff members for assistance with changing his soiled clothes. Several staff members walked by him and instructed R50 to wheel his wheelchair down to his room, and R50 asked staff what his room number was.On 04/22/26 at 10:50 AM, Certified Nurse Aide (CNA) P stated R50 would toilet himself most the time. CNA P stated he had incontinent pull ups located in his bathroom to put on after he had used the toilet if had an incontinent episode. CNA P stated R50 required assistance with toileting at times. CNA P stated the staff would be responsible to ensure R50 was wearing the correct incontinent product on was on correctly to prevent visibly incontinent episodes.On 04/22/26 at 11:00 AM, Licensed Nurse (LN) H stated she had heard R50 on 04/20/26 request assistance with changing his soiled clothes. LN H stated she had instructed him to wheel himself down to his room. LN H stated the direct care staff was responsible for assisting R50 with toileting and ensuring he was wearing the correct incontinent product.On 04/22/26 at 11:20 AM, Administrative Nurse D stated R50 was able at times to complete his own toileting task with cues from the staff. Administrative Nurse D stated she expected the staff to check on him to ensure his clothes were changed and he was wearing the correct incontinence product correctly to prevent soiled clothes.The facility's Quality of Life - Activities of Daily Living policy, dated 03/2026, documented the facility environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being. Residents who are unable to carry out activities of daily living received the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene.

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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** Based on interviews, observation, and record review, the facility failed to ensure staff implemented interventions per the plan of care for Resident (R) 50 to prevent further falls and possible injuries. Findings included:- R50's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of repeated falls, dementia (a progressive mental disorder characterized by failing memory and confusion), abnormalities of gait and mobility, difficulty walking, muscle wasting and atrophy (wasting or decreasing in size of a part of the body), need for assistance with personal care, and lack of coordination.The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R50 had bilateral lower extremity limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R50 required substantial to maximum staff assistance for toileting and lower body dressing. R50's Falls Care Area Assessment (CAA), dated 07/18/25, documented he was at risk for falls related to his diagnosis, use of high-risk medications, history of falls, and need for staff assistance with walking.R50's Care Plan, documented the following interventions:02/16/17, staff would determine and address causative factors of the fall. 10/24/19, staff would encourage R50 to ask for assistance when bending over to pick objects off the floor. 09/02/25, staff would ensure R50 was positioned correctly in the wheelchair.During morning rounds staff would encourage use of toilet and/or urinal.During the night staff would prompt him to use bathroom every three hours and asneeded throughout the night.01/23/26, a toilet riser was placed in the bathroom.A bolster was placed on the bed.The care plan lacked an intervention for an unwitnessed fall on 04/17/26.R50?s EMR under the Progress Notes tab revealed a Nursing Note dated 04/17/26 at 03:00 AM, which revealed R50 was found leaning against his roommate's bed. R50 urinated on the floor and slipped. He stated he was attempting to get into his wheelchair.Review of the Facility's Fall Investigation provided by the facility, dated 04/17/26, revealed a note dated 04/20/26 which documented the root cause analysis, which was that R50 had urinated on the floor and slipped in the urine. Staff education would be provided to ensure R50 was wearing the appropriate incontinent product and wearing nonskid socks.On 04/20/2026 at 09:12 AM, R50 sat in his wheelchair in front of the nurse's desk with visibly wet navy pants and blue checkered. R50 asked several staff members for assistance with changing his soiled clothes. Several staff members walked by him and instructed R50 to wheel his wheelchair down to his room and R50 asked staff what his room number was.On 04/22/26 at 10:50 AM, Certified Nurse Aide (CNA) P stated she was able to find fall interventions on the resident's care plans. CNA P stated the nurses would communicate any new interventions to the staff.On 04/22/26 at 11:00 AM, Licensed Nurse (LN) H stated fall interventions could be found in the resident's care plans. LN H stated Administrative Nurse D was responsible to ensure an intervention would be placed on resident's care plan to prevent further falls.On 04/22/26 at 11:20 AM, Administrative Nurse D stated she was responsible for ensuring an intervention was placed on the resident's care plan after the root cause analysis was determined. Administrative Nurse D stated R50's dementia has progressed and R50 had difficulty remembering to call for assistance.The facility's Managing Falls and Fall Risk policy, dated 06/2025, documented based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ).Findings included: - The PBJ Staffing Data Report CASPER Report 1705D provided by the Centers for Medicaid and Medicare (CMS) for Fiscal Year (FY) 2025 Quarter (Q)s 2, 3, and 4 and Fiscal Year 2026 Q1 documented excessively low weekend staffing.Review of the facility's actual working schedule sheets from 10/01/25 to 03/31/26 revealed the facility maintained and had the same number of staff scheduled and worked as during the week: One or two nurses for day shift and one nurse for evening and night shift; three to four nurse aides day shift and two nurse aides on evening and night shift; one medication aide on day and evening shift.The facility's Facility Assessment, revised on 11/20/25, documented the specific needs of each resident in the community were identified and staffing was adjusted as needed. The facility assessment included staffing for each shift. The direct care staff was to have one to two licensed nurses for day shift, and one licensed nurse for evening, and night shift; one medication aide on day and evenings; three to four nurse aids on days and two nurse aides on evening shift, and night shift; and one medication aide for day, and evening shift.On 04/21/26 at 08:06 AM, Administrative Staff A stated she was unsure why the facility showed extremely low weekend staffing on the PBJ. She stated she thought the PBJ triggered for low staffing due to the fact the facility had terminated a nurse and the facility had one nurse pass away. Administrative Nurse A stated those numbers reflected the facility's PBJ. She stated although the nurses were no longer working in the facility, the facility maintained staff as the facility assessment documented.The facility's Payroll Based Journal, dated 10/26, documented our community would submit payroll data in a uniform format to CMS, including staffing information for community, agency and contract staff. Direct Care Staff were defined as those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long-term care facility.