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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER Peabody Health and Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 407 N Locust Street Peabody, KS 66866 | |

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) |
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| <p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>32360</p> <p>The facility had a census of 39 residents, with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide the correct CMS form 10123, Notice of Medicare Non-Coverage (NOMNC) for two residents, Resident (R) 1 and R23. The facility also failed to include the estimated cost to continue skilled services on CMS form 10055, Advanced Beneficiary Notice (ABN), to the resident or their representative for the two residents, R1 and R23. This deficient practice placed the two residents at risk for uninformed decisions regarding skilled care.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Medicare NOMNC informed beneficiaries of their discharge and their right to an expedited review of the determination to terminate skilled coverage. The ABN form informed the beneficiaries of the estimated cost to continue their services, <p>The facility's Medicare NOMNC form was not provided to R1 (or their representative), and the ABN form staff provided to R1 (or their representative) lacked the estimated cost to continue services when the resident's skilled services ended on 10/25/24.</p> <p>The facility's Medicare NOMNC form was not provided to R23 (or their representative), and the ABN form staff provided to R23 (or their representative) lacked the estimated cost to continue services when the resident's skilled services ended on 08/19/24.</p> <p>On 01/29/25 at 10:00 AM, Administrative Nurse E stated he was not aware that he was supposed to provide the residents or their representatives with the NOMNC forms when skilled services ended. Administrative Nurse E stated the facility had recently changed therapy companies and was unsure of the estimated cost of continuing skilled services.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility's Beneficiary Notices policy, dated revised 08/24, documented the skilled nursing facility must give notice to the beneficiary at least three days before termination of all Part A services when the beneficiary still had days left in the benefit period. The facility would use the Medicare Provider Non-Coverage, Form CM'S 10123, to inform the beneficiary on how to request an expedited redetermination. Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN), CMS 10055, must be issued to the resident if the resident intends to continue services and the facility had determined that the services may not be covered under Medicare. The resident must be informed of potential non-coverage and document in the record that the resident understands they are accepting financial liability.</p> <p>The facility failed to provide R1 and R23 the CMS 10123 as required and failed to provide R1 and R23 the estimated cost to continue skilled services. This deficient practice placed the residents at risk for uninformed decisions regarding skilled services.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32358</p> <p>The facility had a census of 39 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one of one kitchen. This deficient practice placed the residents who received their meals from the facility's kitchens at risk for foodborne illness.</p> <p>Findings included:</p> <p>- On 01/28/25 at 07:42 AM, In a three-door refrigerator, an unsealed plastic bag of yellow shredded cheese, an unlabeled updated 1 1/2-pound (lb.) plastic bag with white cheese, and an unlabeled, undated zip-lock plastic bag with two round slices of meat.</p> <p>A two-door silver freezer located in the storage room across the hall from the kitchen was an undated three-gallon container of orange sherbet with numerous different-sized dried orange substances around the outside of the container.</p> <p>An unsealed, approximately 3/4 full, 50 lb. bag of flour and an unsealed, approximately 1/4 full, 50 lb. bag of breadcrumbs.</p> <p>On 01/28/25 at 08:20 AM, Dietary Staff (DS) BB verified the above findings and stated staff should label and date food items before placing them in the refrigerator. DS BB stated staff should place flour and breadcrumbs in a sealed container after opening the bag.</p> <p>On 01/29/25 at 10:50 AM, the mopboard around the kitchen's perimeter had numerous different sizes of grayish-black substances on it.</p> <p>The pipes underneath the dishwasher, approximately two feet long, had numerous areas of different sizes of grayish-black substance.</p> <p>On 01/29/25 at 10:50 AM, DS CC verified the above finding and stated the dietary staff should clean the mopboard and the pipes underneath the dishwasher.</p> <p>On 01/30/25 at 09:55 AM, Administrative Nurse D stated the administrator was overseeing the dietary department until next week when the new dietary manager became employed at the facility.</p> <p>The facility's Food Safety Requirements Policy, revised 10/2024, documented that all foods stored in the refrigerator or freezer would be covered, labeled, and dated.</p> <p>The facility's Sanitation Policy, updated 10/2024, documented all kitchens, kitchen areas, and dining areas should be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. Kitchen and dining room surfaces not in contact with food would be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. The food services manager was responsible for scheduling staff for regular cleaning of the kitchen and dining areas.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>The facility failed to store, prepare, distribute, and serve food by professional standards for food service safety for the 39 residents who received their meals from the facility's kitchen. This deficient practice placed the 39 residents at risk for foodborne illness.</p> |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358</p> <p>The facility had a census of 39 residents. The sample included 12 residents, with two reviewed for hospice services. Based on observation, record review, and interview, the facility failed to ensure a communication process between the hospice provider and the facility for Resident (R)25, who was admitted to hospice on 09/08/24, and R19, who was admitted on [DATE], which included a plan of care and a description of the services provided which included contact information, visit frequency, medications, and medical equipment. This deficient practice placed R25 and R19 at risk of not receiving needed care.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R25's Electronic Health Record (EHR) revealed diagnoses of atherosclerotic heart disease (a condition that occurs when plaque (fatty material) builds up in the arteries of the heart), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). <p>R25's Quarterly Minimum Data Set (MDS), dated [DATE], documented R25 had a Brief Interview of Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. The MDS document R25 was dependent on staff with toileting, showering, putting on and taking off footwear, and personal hygiene. R25 was partial to moderate assistance with oral hygiene, sitting to standing position, chair to bed/ bed to chair transfers, and toilet transfers. R25 required substantial to maximal staff assist with upper and lower body dressing, sitting to lying, supervision with eating, independent with bed mobility, and propelling in a wheelchair.</p> <p>R25's Care Plan, dated 12/16/24, recorded R39 required extensive assistance with most activities of daily living (ADLs). R25's Care Plan documented the resident was admitted to [hospice services] on 09/08/24. The care plan directed the staff to administer medications ordered and notify the physician if there is breakthrough pain, assist with supporting the function of ambulation and mobility to the extent needed, talk to the resident during all encounters to avoid isolation and encourage visits from family and friends. The care plan lacked instruction on the services provided by hospice, including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.</p> <p>A review of R25's clinical record revealed the resident was admitted to hospice care on 09/06/24. The facility lacked a hospice plan of care.</p> <p>(continued on next page)</p> | | |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The hospice agreement documented the hospice plan of care would specify the hospice care and hospice services necessary to meet the needs of the hospice resident. The agreement documented the resident and his/her family would be identified in the initial comprehensive care plan, and staff would update assessments as necessary for the palliation and management of the resident's terminal illness and related conditions. The hospice care plan would provide the frequency of service, interventions to manage pain, drugs, supplies, appliances, and clinical record documentation and would coordinate care with the facility.</p> <p>01/28/25 at 02:53 PM, R25 self-propelled in a wheelchair to the activity room and sat quietly waiting to have nails done, no signs or symptoms of pain.</p> <p>01/29/25 at 04:48 PM, Administrative Nurse D verified R25's clinical record lacked a hospice care plan.</p> <p>01/30/25 at 12:19 PM, Administrative Nurse D verified the facility lacked R25's hospice care plan and stated she had faxed hospice today and requested it. Administrative Nurse D verified the resident's care plan lacked information regarding hospice visits, phone numbers, and medical supplies. Administrative Nurse D stated Administrative Nurse E was responsible for updating care plans.</p> <p>01/30/25 at 12:19 PM, Administrative Nurse E verified he was responsible for updating the care plans and was unaware the hospice information regarding contact number, medical supplies, phone numbers, and hospice visits were to be included in R25's care plan.</p> <p>The facility's Hospice Program Policy, updated 10/2024, documented that hospice would identify in writing the services hospice would be providing, address in the resident's person-centered care plan, and the facility would provide collaboration and coordination of hospice care. The policy-documented facility would ensure the appropriate documents were readily available, which included the hospice plan of care.</p> <p>The facility failed to coordinate care between the facility and the hospice provider for R25, who received hospice services. This deficient practice placed him at risk for inadequate end-of-life care.</p> <p>32360</p> <p>- R19's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin type 2, and multiple sclerosis (MS - progressive disease of the nerve fibers of the brain and spinal cord).</p> <p>R19's Significant Change Minimum Data Set (MDS), dated [DATE], documented R19 had severely impaired cognition. R19 was dependent upon staff for all ADLs, was incontinent of bladder and bowel, and required supplemental oxygen.</p> <p>(continued on next page)</p> | | |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R19's Care Plan, dated 01/21/25, documented R19 received hospice services and directed staff to assist her with eating, provide comfort measures as ordered, listen to her concerns, and ensure her call light was in reach. The care plan lacked instruction on the services provided by hospice, including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.</p> <p>A review of R19's clinical record revealed the resident was admitted to hospice on 01/17/25. The facility lacked a hospice plan of care.</p> <p>The hospice agreement documented the hospice plan of care would specify the hospice care and hospice services necessary to meet the needs of the hospice resident. The agreement documented the resident and his/her family would be identified in the initial comprehensive care plan, and staff would update assessments as necessary for the palliation and management of the resident's terminal illness and related conditions. The hospice care plan would provide the frequency of service, interventions to manage pain, drugs, supplies, appliances, and clinical record documentation and would coordinate care with the facility.</p> <p>On 01/29/25 at 12:15 PM, R19 sat in her wheelchair, feet elevated, and she had oxygen on.</p> <p>01/29/25 at 04:48 PM, Administrative Nurse D verified that R19's clinical record lacked a hospice care plan.</p> <p>01/30/25 at 12:19 PM, Administrative Nurse D verified the facility lacked R19's hospice care plan and stated she had faxed hospice today and requested it. Administrative Nurse D verified the resident's care plan lacked information regarding hospice visits, phone numbers, and medical supplies. Administrative Nurse D stated Administrative Nurse E was responsible for updating care plans.</p> <p>01/30/25 at 12:19 PM, Administrative Nurse E verified he was responsible for updating the care plans and was unaware the hospice information regarding contact number, medical supplies, phone numbers, and hospice visits were to be included in R19's care plan.</p> <p>The facility's Hospice Program Policy, updated 10/2024, documented hospice would identify in writing the services hospice would be providing, address in the resident's person-centered care plan, and the facility would provide collaboration and coordination of hospice care. The policy-documented facility would ensure the appropriate documents were readily available, which included the hospice plan of care.</p> <p>The facility failed to coordinate care between the facility and the hospice provider for R19, who received hospice services. This deficient practice placed her at risk for inadequate end-of-life care.</p> | | |