STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175477	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leonardville Nursing Home	409 W Barton Street Leonardville, KS 66449

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 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** 26768 The facility had a census of 48 residents. The sample included 12 residents with eight reviewed for accidents. Based on observation, interview, and record review the facility failed to identify causative factors for falls and implement meaningful, resident-centered interventions, including adequate supervision, to prevent falls for Resident (R) 13 who experienced repeated falls in the past year. The facility failed to assess interventions that were in place to ensure the interventions were appropriate and to monitor the effectiveness of the interventions. This deficient practice placed R13 at risk for ongoing falls and injuries. Findings included: - R13's Electronic Medical Record documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), macular degeneration (progressive deterioration of the retina), unsteadiness, repeated falls, age-related cognitive decline, chronic left leg weakness, and an ataxic gait (difficulty walking in a straight line and may stagger or shuffle). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. The MDS documented R13 had no behaviors. R13 required staff supervision for transfers, moderate staff assistance with upper body dressing, maximum assistance for toileting, and total assistance for lower body dressing, footwear, and wheelchair mobility. The MDS documented R13 was frequently incontinent of bowel and bladder. R13 had more than two non-injury falls, and one fall with minor injury since the prior MDS. The MDS documented R13 received anticoagulant (medication that stops blood from clotting too easily) medication. R13 had a bed and chair alarm used daily. R13's Fall Care Plan, dated 08/12/24, listed the following undated fall interventions: R13 will be reminded to use a call light for staff when he has needs. He is educated to wait for staff to help him. Staff will provide stand-by to maximal assistance when assisting R13 to the bathroom and or when he is up ambulating. He will have his shoes on or gripper socks when he wants to get up. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's call light will remain within reach. A pressure alarm system will be used when in bed and chair. R13 would have a room with straight access to the room, without turns in the hallway during the nights. R13's water cups and other personnel items will remain within his reach. R13 uses a walker, and his walker will remain within reach. R13 has been more unsteady, his strength was declining, and a walker will be used as he is able, but a wheelchair is being utilized as well. R13's bed will remain in a low position. Staff will assist R13 with bathroom needs and incontinent care and will keep floors clutter-free and dry. R13 will be toileted every two hours and no longer than three hours. Staff will make frequent visual checks. Staff were to assist R13 with bedtime care when he walked back to his room after supper. There were two extra sensitive call pads in place and staff continued training to the sensor alerts. Staff were to offer to take R13 to the bathroom more often to reduce how often his wife tried to take him. Staff will call for extra help when R13 is not standing, walking, or transferring. Staff were to place a sensor alert in a location that can be heard if staff are not in the dining room. Staff were to encourage R13 to move more slowly when adjusting positions. The Neighborhood Care Plan directed staff to use one to two staff for activity of daily living (ADL) assistance for R13 with a walker or a wheelchair. R13's Fall Risk assessment dated [DATE], 05/06/24, and 08/05/24 all indicated R13 was at high risk of falling. A review of the fall note documentation revealed the following falls: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/30/24 Staff responded to the call light. Upon entering the room, R13 was found on his knees next to his bed with his spouse in front of him with the wheelchair. He denies pain or hurting himself. He was assisted off the floor via assistance from two staff, Staff then assisted him to the bathroom. He was able to R13 ' s souse was getting back in bed when staff came out of the bathroom. Staff told her R13 would be done soon and then she could go in, and she said, No I just was in there. Staff have verbalized that R13's spouse does not always realize whether R13 has been to the bathroom so when she has to use the bathroom, she wakes him to get up as well. Most of those times, staff report they had toileted R13 between 30 minutes to one hour prior. R13 did not void when he got up and his pull-up was dry. Staff will offer R13 ' s spouse toileting after he is assisted to let her know that R13 has been to the bathroom. Staff assisted R13 back to bed, the call lights were in place, and the sensor pads were in place. 05/15/24 R13's call light went off and staff immediately responded. Upon reaching the room, R13's spouse was leaving the room to get help for R13, who was on the floor. R13 was found on the right side of the bed, sitting on his buttocks. He was alert and smiling when staff greeted him. He said he got out of bed alone and was going to the bathroom and he lost his balance and fell . No injuries were noted. The note documented the resident used a pressure sensor alert to assist staff to reach him when he got up, but the sensor pad did not go off. Staff tested and the staff were unable to get it to alert. The resident had a chair pressure sensor that was functioning, so staff placed the chair pad in R13 ' s bed to help ensure alert notifications. Staff reminded R13 to allow staff to help him get up. He smiled and nodded. The note recorded the call light and both bed and chair alarms were placed. On this date at 11:52 AM a new bed sensor was put on this and working correctly. 05/19/24 R13 was self-transferring in his room with his spouse, lost balance, and fell . He was not using a walker. Staff assisted him into a wheelchair and then into the bathroom and he voided well. Staff assisted R13 back to bed; there was a pressure pad on the bed with an alarm set. The call light was within reach. The floors were dry and clutter-free. 06/10/24 At around 07:35 PM R13's spouse came down the hall, stood outside the dining room, and informed staff that R13 was on the floor. Staff assessed and noted R13 sitting on the floor with his legs bent, extended out, facing towards the door, between the recliner and window end table. His back was against the recliner and table. He had shoes on his feet, and he stated he was trying to get up to go to the bathroom. Staff emphasized to R13 and his wife that it was extremely important for R13 to use his call light before he got up. Staff assisted R13 to the bathroom. 06/11/24 Staff immediately responded to R13's call light. When staff entered the room, R13 was sitting at the side of his bed smiling. When asked what he was doing he said he was just getting up. R13's spouse said he just slid off the side of the bed. Staff educated both on the importance of calling for help. And R13's spouse said, Well we don't need to do that every time, and the staff instructed her Yes every time. R13's spouse did not respond and walked away. Staff assisted R13 off the floor with maximal assistance and helped R13 into the wheelchair. Staff assisted R13 into the bathroom and he voided with no difficulty and then back to bed. His call light was within reach and positioned to alert staff quickly if he started to get up alone. His pressure pad alert system was on the bed, but this did not send out an alert tone. Staff checked the pad, and it did respond appropriately with tests. Staff were educated on the appropriate placement of the pad. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/20/24 A staff member went to answer R13's call light and he was sitting on the floor in front of his recliner reading a magazine. He laughed when the staff entered and said he was trying to get his magazine when he slid out of his chair. His chair sensor was not working. Staff questioned if a wire was broken within the chair alarm. Staff placed a new sensor alert sensor alert in place. 06/21/24 R13's spouse was in the hall looking for help due to R13 was on the floor. When staff entered the room, R13 sat with his back against the wall. He was alert and pleasantly confused and stated he was going to the toilet and fell . Staff assisted R13 to a standing position and then assisted him into the wheelchair and to the toilet. R13's brief was dry, and he voided in the toilet with no difficulty. R13's call light was on the floor and his pressure pad did not alert. Staff tested the pad and it worked appropriately. The note recorded the resident was assisted to bed and positioned appropriately for the pressure pad to work. R13's pancake call light was at his side and an additional call light as well. Staff provided verbal education and explained the consequences of falling. 07/06/24 Staff heard R13's sensor going off and went to the resident ' s room when she got off the phone. R13 was sitting on the floor. R13's spouse was trying to help him up. Staff assisted R13 up. Staff were in other residents' rooms and did not hear the sensor. Staff noted they would place the alarm where it would be better heard when staff were not in the great room. 07/16/24 Staff were alerted to the R13's room by the sensor alert. As staff entered, staff observed R13 take a few steps with his walker following his spouse. She was in the walkway, at the foot of the bed and he was not in reach of me. He looked up as staff came in, lost his balance, and fell . Staff received education to get R13 out to lunch at 11:15 AM since his spouse watched the clock and he was following her out. 07/17/24 At 11:05 AM, R13's sensor alerted staff to his room. R13 was sitting on the floor a few feet from his recliner. He said he was trying to see his calendar that was hanging up to find out the date to order his books. His wheelchair was close to the recliner, but his walker was not in reach. 07/18/24 At 9:50 PM the CNA reported R13 fell in the bathroom. Upon assessment staff noted R13 sitting on the floor with his back against the wall, facing the sink and commode. He had his shoes on. Staff assisted R13 to his feet and then helped with toileting. The note documented that neither R13's wheelchair nor walker were in sight. 07/22/24 at 09:10 PM the CNA reported that R13 was on the floor in his bathroom. Upon assessment, staff noted R13 sitting on the floor with his legs extended and his knees slightly bent. His back was up against the toilet. 07/30/24 R13 was assisted off the floor. He had an abrasion to his left lower lateral back. 08/04/24 At 06:15 PM, the Certified Medication Aide (CMA) alerted the nurse that R13 was sitting on the floor in his room. Staff entered to find another CNA with R13. The CNA stated she was coming in to assist R13 because the resident's alarm was sounding but she could not get to the resident in time. R13 had already stood up from his recliner and it appeared his lower legs gave out and he sat down on the floor. He had shoes on. R13 stated he was trying to go to the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/17/24 At 04:32 PM R13 self-transferred from the toilet to his wheelchair and fell to the floor. He landed on his bottom and denied any pain. Staff transferred him to the bathroom, but R13 did not use the call light after he was done using the toilet. He had a very small 0.3-centimeter (cm) skin tear on his right hand. The area was cleansed, and staff placed adhesive closure strips. 08/29/24 At 03:45 PM staff found R13 on the floor. Upon assessment, staff noted R13 sitting on the floor between his recliner and his spouse's. His legs were extended R13 stated he was trying to go the bathroom; staff assisted him to his feet and into the wheelchair. 09/03/24 At 04:00 PM staff found R13 on the floor between his recliner and his spouse's recliner. He was facing towards the back wall with his legs extended. He was trying to sit up and his spouse was standing over him. Staff asked R13 if he hit anything or had any pain and R13 answered no to each. 09/19/24 At 02:57 AM, R13's spouse came out into the hall and said R13 was on the floor. R13's call light was not on; the pressure alarm did not alarm. Upon entering the room, staff observed R13 sitting on his buttock/right hip in front of the bathroom door. He was awake and pleasantly confused per his baseline. He just smiled at the staff and denied hitting his head. Staff assisted R13 into his wheelchair and then assisted him to the bathroom. R13 voided with no difficulty. Staff checked the alarm prior to sitting the resident on it to check for proper functioning and placed additional call lights around the resident for early notification. Staff reminded R13 and his spouse to call staff for help. On 10/30/24 at 12:39 PM, observation revealed CMA S assisted R13 in his wheelchair to his room to the toilet. R13's wheelchair had an anti-rollback, anti-tip devices, and a non-slide pad in the seat along with a sensor alarm. R13 had problems lifting his feet when turning into the bathroom. Observation revealed no non-slip strips in the bathroom, but there were some in front of his recliner. When he stood at the toilet, the sensor alarm alerted other staff who came to check. CNA S did not use a gait belt for the transfers but instead assisted R13 by pulling on the resident's pants. There was a gait belt on R13's dresser. On 10/31/24 at 09:39 AM, Administrative Nurse D stated the staff had attempted numerous interventions to prevent R13's falls and she verified some of the interventions in place were not effective. She stated the facility had issues with the sensor alarms not working and had replaced three of them. She agreed staff should use a gait belt instead of pulling R13's clothing for transfers when the resident demonstrated weakness. The facility's Fall Prevention Protocol stated each elder residing in the facility would be provided care and services to ensure the elder's environment remained as free from accident hazards as possible and each elder received adequate supervision and assistive devices to prevent accidents. The protocol stated the neighborhood team would develop a plan for services to improve or maintain the elder's standing and sitting balance and other interventions to reduce the elder's risk for falls. The plan would include information about the elder's routine and personal habits that may place the elder at risk for falls. Every team member would be responsible for checking either the care plan of elders who were at risk for falls or the neighborhood care tracker. Fall would be evaluated on a weekly basis by the leadership team and by the QAPI committee. The teams would review the number of falls and the effectiveness of implemented care plan interventions. Interdisciplinary team members would contribute to finding alternative interventions if indicated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to identify causative factors for falls and implement meaningful, resident-centered interventions, including adequate supervision, to prevent falls for R13. The facility further failed to assess interventions that were in place to ensure the interventions were appropriate and to monitor the effectiveness of the interventions. This deficient practice placed R13 at risk for ongoing falls and injuries.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 48 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure an appropriate indication for the use of an antipsychotic (a class of medications used to treat a mental disorder characterized by gross impairment testing) or the required physician documentation for two of five residents, Resident (R) 26, and R31, reviewed for unnecessary medications. This placed the residents at risk for unnecessary psychotropic (alters mood or thought) medications. Findings included: - R26's Electronic Medical Record (EMR) documented R26 had diagnoses of restlessness, agitation, and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R26's Quarterly Minimum Data Set (MDS), dated [DATE] documented R26 had a Brief Interview of Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. The MDS documented R26 required substantial to maximal staff assistance with showering and dressing. R26 required partial to moderate staff assistance with toileting hygiene and personal hygiene. He required set-up assistance for eating and was independent with bed mobility, most transfers, and ambulation. The MDS documented that R26 received an antipsychotic medication during the observation period. R26's Care Plan, revised 10/21/24, documented R26 could be anxious and exit-seeking. The plan noted R26 received Seroquel (an antipsychotic medication) and instructed staff to monitor for Black Box Warning (BBW-the highest safety-related warning that medications can have assigned by the Food and Drug Administration) and adverse reactions of the medication. The Physician Order, dated 08/18/23, instructed staff to administer Seroquel, 150 milligrams (mg), by mouth once daily at bedtime, for agitation and restlessness. The Consultant Pharmacist [CP] Regimen Review, documented the use of antipsychotics for diagnoses other than schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), or Tourette's (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds) was discouraged and requested the physician provide one of the three diagnoses for R16's Seroquel order on the following dates but lacked evidence that the physician addressed the recommendations on the following review dates: 01/05/24, 02/04/24, 03/06/24, 04/03/24, 05/06/24, 07/08/24, 08/05/24, 09/02/24, and 10/08/24. R26's clinical record lacked evidence of physician documentation which included a rationale and risks versus benefits for R26's continued use of Seroquel. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 09:00 AM, observation revealed R26 sat quietly at the kitchenette counter and visited with another female resident sitting by her. On 10/31/24 at 09:34 AM, Administrative Nurse D verified the resident's Seroquel had an inappropriate indication and stated the facility staff tried to get the physicians on board with the proper documentation for antipsychotic medications. The facility's Psychotropic Medication Use Policy, undated, documented the physician's order for a psychotropic drug would include both a qualifying diagnosis for the drug and a list of behaviors that the staff would monitor during the drug administration. The facility failed to ensure an appropriate indication for use, or the required physician documentation for R26's Seroquel. This placed the resident at risk for unnecessary psychotropic medications. - R31's Electronic Medical Record (EMR) documented R31 had a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R31's Quarterly Minimum Data Set (MDS), dated [DATE], documented R31 had a Brief Interview of Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The MDS documented the resident received antipsychotic medications every day during the observation period. R31's Care Plan, revised 09/09/24, documented R31 had physician orders for routine Seroquel (antipsychotic medication). The plan noted R31 could be agitated and would yell. The Physician Order, dated 07/15/24, instructed staff to administer R31 Seroquel, 25 milligrams (mg) tablet twice a day for unspecified dementia, without behavioral disturbance, psychotic (a term used to describe a collection of symptoms that cause [NAME] to lose touch with reality) disturbance, mood disturbance, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Physician Order dated 09/26/24 instructed staff to administer R31 Seroquel, 50 mg tablet twice a day for unspecified dementia, unspecified severity, without behavioral disturbance. The Consultant Pharmacist [CP] Regimen Review, documented the use of antipsychotics for diagnosis other than schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), or Tourette's (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds) was discouraged and requested the physician provide one of the three diagnoses for R31's Seroquel order on the following dates, but the physician did not address the recommendation: 08/06/24, 09/09/24, and 10/01/24. R31's clinical record lacked physician documentation which included the rationale and risks versus benefits for R31's continued Seroquel use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 10:49 AM, observation revealed R31 sat quietly in a wheelchair at the dining room table at an activity. On 10/31/24 at 09:34 AM, Administrative Nurse D verified the resident's Seroquel had an inappropriate indication for use and stated the facility staff tried to get the physicians on board with proper documentation for antipsychotic medications. The facility's Psychotropic Medication Use Policy, undated, documented the physician's order for a psychotropic drug would include both a qualifying diagnosis for the drug and a list of behaviors that the staff would monitor during the drug administration. The facility failed to ensure an appropriate indication for use, or the required physician documentation for R31's Seroquel. This placed the resident at risk for unnecessary psychotropic medications.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 48 residents. The sample included 12 residents with two reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)16 and R11. This placed the residents at risk for inadequate end-of-life care. Findings included: - R16's Electronic Medical Record (EMR) documented the resident had diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), senile degeneration of the brain (age-related cognitive decline), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), and hypertension (HTN-elevated blood pressure). R16's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R16 had a Brief Interview of Mental Status (BIMS) score of three which indicated severe cognitive impairment. The MDS documented R16 required total staff assistance with toileting hygiene, showering, lower body dressing, putting on and taking off footwear, and personal hygiene. R16 required partial to moderate staff assistance with rolling left and right in bed, lying to sitting position, and sit to stand transfers. R16 required supervision with oral hygiene, upper body dressing, transfers, and ambulation. The MDS documented R16 received hospice services. R16's Care Plan, revised 10/25/24, documented R16 required one staff assist with a gait belt for transfers. R16 ambulated with a front-wheeled walker, and used a wheelchair with a cushion when she was tired. The care plan lacked documentation with guidance for staff regarding contact information for hospice services, hospice visit frequency, and the medications, equipment, and supplies hospice would provide. The Physician Order, dated 06/14/2024 at 09:26 AM, instructed staff to admit R16 to hospice service. On 10/31/24 at 02:00 PM, observation revealed a hospice notebook at the Serenity House nurse's station. On 10/30/24 at 02:12 PM, observation revealed R16 sat in a recliner in her room without signs or symptoms of pain. On 10/30/24 at 04:13 PM, Administrative Nurse E verified R16's hospice section of the care plan lacked information for staff regarding the hospice service contact information, visit frequency, medications, and supplies hospice would supply. Administrative Nurse E stated she was responsible for updating care plans and said she should update the care plans with that information. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 10:00 AM, Administrative Nurse D verified that R16's hospice section in her care plan lacked information regarding hospice contact information, visit frequency, medications, and supplies hospice would provide and stated she was unaware that information should be included in the facility's care plan. The facility's undated End of Life, Palliative and Hospice Care documented palliative assessment and documentation are interdisciplinary and coordinated between the facility, physician, and any hospice provider involved in the care of the resident. The facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility and the hospice provider for R16. This placed the resident at risk for inadequate end-of-life care. 26768 - R11's Electronic Medical Record (EMR) included a diagnosis of atherosclerotic heart disease (damage or disease in the heart's major blood vessels). The Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. The MDS documented R11 required maximum assistance to total dependence on staff for activities of daily living. The MDS documented R11 received as-needed (PRN) pain medications and had frequent moderate pain. R11 received hospice services. R11's Care Plan, dated 08/09/24, stated R11 was on hospice related to multiple hospitalization s and atherosclerotic heart disease. The plan directed staff to see the Terminal Prognosis [SOP] Standards of Protocol. The plan included sections to list durable medical equipment and supplies provided however none were listed. The plan directed staff to notify the hospice provider of changes and to avoid hospitalization s. R11's Care Plan lacked specific information regarding the hospice contact information, the medications, supplies, and equipment provided by the hospice, and the frequency of hospice staff visits. The hospice provided Hospice Care Plan, dated 07/27/24, stated the hospice nurse would visit six times as needed, one to three times per week for 12 weeks. The plan noted the social worker would visit one to three times per month for three months. The care plan included goals and interventions. On 10/30/24 at 10:50 AM, observation revealed R11 sat in a wheelchair in her room with one shoe off, watching TV. There were two hospice staff visiting with her. On 10/29/24 at 01:55 PM, Licensed Nurse (LN) G stated hospice staff visited the resident that day and they usually come twice per week. LN G said the hospice nursing staff communicated with facility nursing staff through faxes and the hospice notebook. She verified the name of the hospice, and their contact phone number was not in the facility care plan. On 10/31/24 at 09:33 AM, Administrative Nurse D verified the name of the hospice, their contact phone number, and what medications and supplies they were responsible for were not in the facility's care plan for R11. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175477	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leonardville Nursing Home	409 W Barton Street Leonardville, KS 66449

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's End of Life, Palliative and Hospice Care policy stated the interdisciplinary team in collaboration with the resident, family, and other involved health care professionals, would develop the care plan. When possible, hospice program staff participate in each other's team meeting to promote regular professional communication, collaboration, and an integrated plan of care. The facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for R11. This deficient practice placed R11 at risk for inadequate end-of-life care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175477	A. Building B. Wing	10/31/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 26768 The facility had a census of 48 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure staff followed appropriate infection control standards related to a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) care for Resident (R) 19. This deficient practice placed R19 at increased risk for infections. Findings included: - On 10/30/24 at 07:55 AM, observation revealed Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) N donned personal protective equipment (PPE-gloves and gowns) and entered R19's room. R19 was in a low bed. R19's urinary catheter bag was uncovered and lay directly on the bare floor. CMA R verified the bag should not be touching the floor. CMA R provided peri-care, and cleaning around the catheter insertion site and tubing. CMA R provided bowel incontinence care, then removed her soiled gloves and washed her hands. CMA R applied new gloves, wiped R19's bottom one more time, and then emptied the catheter bag wearing the same contaminated gloves. She used an alcohol wipe on the catheter port, removed her soiled gloves, and then removed her other PPE before leaving the room. On 10/31/24 at 09:30 AM, Administrative Nurse D verified staff should change gloves after providing peri-care and before touching the catheter bag and tubing. She verified the catheter bag should not have been allowed to lie on the floor. The facility's Indwelling Catheter Protocol states staff should wash hands or perform hand hygiene immediately before and after any manipulation of the catheter site or drainage bag. The staff were not to allow the catheter bag or tubing to touch the floor. The facility failed to provide proper infection control practices during urinary catheter care for R19, placing R19 at risk for infection.