STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175533	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Health and Rehab	757 W Eisenhower Rd Lansing, KS 66043

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 45668 The facility identified a census of 54 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances and concerns. Findings Included: - On 08/27/24 at 07:00 AM a walkthrough of the facility was completed. An inspection of the main entry lobby revealed a grievance box posted to the left side of the lobby. A grievance form bin was next to the grievance box but lacked available grievance forms. The form bin remained empty throughout the survey exit on 08/29/24 at 12:00 PM On 08/28/24 at 01:30 PM, the Resident Council members reported a grievance drop-box was posted in the main lobby. The council reported they would have to ask staff for the forms to fill out and then could either give the forms to staff or put them in the box. The council reported they were not aware if they could get the forms without asking staff. On 08/29/24 at 10:03 AM Social Service Staff X stated the grievance forms were kept at the nurse stations and the main lobby desk for the residents to fill out. She stated the residents could ask staff to get the forms and drop them off to either herself or the administration office. She stated residents on the units with locked doors could also ask staff to bring them to the main lobby to fill one out. She was not aware the main lobby grievance form bin had no forms available for the residents and their visitors and stated she would put the forms in the bin. On 08/29/24 at 10:15 AM Certified Medication Aide (CMA) R stated she was not sure if the facility had a grievance form available in the common areas for the residents to fill out but stated the forms were kept at the nurses' stations. She stated the residents could ask the staff to get the forms. The facility's Grievances policy revised 11/2017 indicated the facility would ensure each resident's right to file a grievance in writing, verbally, or anonymously. The policy indicated the facility will ensure the grievances were documented and ensure all written decision included corrective actions and prompt resolution. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously within the facility. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 54. The sample included 14 residents with 14 reviewed for comprehensive care plans. Based on observation, record review, and interview, the facility failed to develop comprehensive care plans that included Resident (R)39's activities of daily living (ADL) and incontinence care. This deficient practice placed the resident at risk for impaired care due to uncommunicated care needs. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), and dementia (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R39 was dependent on staff assistance for toileting, transfers, dressing, bathing, personal hygiene, and repositioning. The MDS documented R39 was at risk of developing pressure ulcers and had a history of falls prior to admission. The MDS documented R39 had functional limitations to one side of her upper and lower extremities. The MDS documented R39 was frequently incontinent of bladder and always incontinent of bowel. R39's Functional Abilities Care Area Assessment (CAA) dated 08/15/24 documented she required total staff assistance with her mobility and activities of daily living. R39's Urinary Incontinence and Indwelling Catheter CAA dated 08/15/24 documented she was incontinent of bowel and bladder and required total assistance from staff for toileting needs. R39's Falls CAA dated 08/15/24 documented she had a history of falls and a recent CVA and required total staff assistance with transfers. R39's Care Plan dated 07/25/24 directed the staff she took medications that had special warnings. The plan of care included interventions for advanced directives and her discharge plan. The plan of care dated 08/21/24 instructed staff about her restorative program. R39's Care Plan lacked direction to staff related to her ADL needs, prevention of falls, and incontinence care. On 08/27/24 at 09:24 AM R39 laid on her bed. She stated she had an accident and wet the bed. Observation revealed an incontinence brief laid on the floor next to the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/24 at 10:06 AM, Certified Medication Aide (CMA) R stated everyone had access to the resident's care plan or the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CMA R stated the care plan should have individualized interventions or approaches for residents with special needs. CMA R stated the facility used a spreadsheet that contained information about each resident and their care. CMA R stated the facility's spreadsheets were updated by the unit managers at least weekly. CMA R said if she had questions about what care was needed for a resident, she would ask the nurse. On 08/29/24 at 10:21 AM, Licensed Nurse (LN) H stated everyone had access to the resident's plan of care and Kardex to review. LN H stated staff utilized care sheets for the CNAs; the unit managers made sure the resident's information was on the care sheets. LN H stated the resident's care plan should contain the information from the assessments completed at the time of admission or any changes to determine the care level. LN H stated any individualized interventions should be included in the resident's care plan so anyone who cared for that resident would know that information. On 08/29/24 at 10:30 AM, Administrative Nurse D stated that everyone had access to the resident's care plan and Kardex. Administrative Nurse D stated that the unit managers, MDS coordinator, and herself would make changes and update the resident's plan of care. Administrative Nurse D stated the facility utilized paper care sheets that contained the resident's care information. Administrative Nurse D stated the assessments completed at the time of admission determined what level of care the resident required. Administrative Nurse D stated every resident's care plan should contain individualized and person-centered directions for the staff on the care each resident requires. The facility's Care Plan policy last updated 03/21/24 documented a care plan that would be developed for each resident that included measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs and are consistent with the resident's desires and preferences. The charge nurse was responsible for creating the initial baseline care plan within 48 hours after admission. The baseline care plan must be individualized to address the resident's specific needs. In addition to the baseline care plan, a black box warning care plan and an advance directive care plan must be created. Within 48 hours, the CAA/Care Plan Coordinator or designee must initiate the discharge care plan. This care plan should be designed to address the resident preferences and needs to enable discharge. It should be updated on an ongoing basis as the resident achieves goals and progresses toward discharge. The physician's orders are considered part of the overall plan of care; therefore, the details of the orders do not need to be included in the care plan interventions. A comprehensive care plan must be developed within seven days of completion of the MDS and CAAs or within 21 days after admission, whichever comes first. This care plan should reflect individualized problems, goals, and interventions based on the resident's preferences and wishes. The comprehensive care plan would be developed after completion of the MDS and CAAs with input from the care planning team, the resident, and the resident's family and/or representative. The facility failed to develop a comprehensive care plan for R39 which included individualized person-centered interventions for incontinence, and ADLs. This deficient practice placed R39 at risk for impaired care due to uncommunicated care needs.

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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 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** 45668 The facility reported a census of 54 residents. The sample included 14 residents with four reviewed for accidents. Based on observations, record reviews, and interviews, the facility failed to provide a safe environment free from accident hazards for Residents (R)15. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - The Medical Diagnosis section within R15's Electronic Medical Records (EMR) noted diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (high blood pressure), dysphagia (difficulty swallowing), impulse disorder (sudden, forceful, irresistible urges to do something), and polyneuropathy (pain related to damaged neural pathways). R15's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated she was dependent on staff for assistance with dressing, toileting, bed mobility, bathing, and personal hygiene. The MDS indicated she used a wheelchair and was dependent on staff for mobility. The MDS indicated she had two or more non-injury falls since her last assessment. R15's Falls Care Area Assessment (CAA) completed 06/06/24 indicated she was at risk for falls related to her impaired cognition, medical diagnoses, and history of falls. The CAA noted she required extensive assistance with her transfers and mobility. The CAA noted a care plan will be created to minimize the risks related to falls. R15's Care Plan initiated on 09/20/20 indicated she required extensive assistance from staff for bed mobility, transfers, bathing, dressing, toileting, and personal hygiene. The plan noted she was at risk for falls and used a smaller wheelchair for mobility. The plan indicated she required a Dycem (non-slip mat) in her wheelchair to prevent her from slipping out. The plan instructed staff to encourage the use of her call light and anticipate her needs. R15's EMR under Progress Note revealed she had a non-injury fall while being transferred to her bed. The note indicated R15's feet were dragging as direct care staff attempted to position her wheelchair next to her bed. The note indicated R15 attempted to lift herself out of her wheelchair resulting in her falling on her bed. The note indicated she was assessed with no injuries. R15's EMR under Progress Notes revealed a note completed on 01/02/24. The note indicated R15 had a history of dropping her feet while being pushed in her wheelchair and the facility will discuss safety concerns with R15's representative. On 08/27/24 at 08:10 AM staff pushed R15 from her room to the dining room table. R15's wheelchair lacked foot pedals and her feet made contact with the floor several times while being moved into position at the table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/24 at 10:11 AM Certified Medication Aide (CMA) R stated all the residents' wheelchairs had foot pedals, but some residents preferred to be pushed without pedals. She stated the resident's feet should never drag or touch the ground during transport due to the risk of injury or falling. On 08/29/24 at 10:28 AM Licensed Nurse (LN) G stated residents that who were cognitively impaired or had lower body weakness should never be pushed without the foot pedals. She stated resident's feet should never be sliding or dragging while being pushed in the wheelchair. On 08/29/24 at 10:35 AM Administrative Nurse D stated staff were expected to utilize the foot pedals when pushing residents around the facility. She stated the foot pedals should be removed at times for residents that can safely propel themselves around the facility. The facility's Falls policy revised 04/2018 indicated the facility will implement systems to reduce the risk of falls based on each resident's assessed needs and treatment. The policy indicated the facility will identify factors including environmental hazards, change of condition, medications, and adaptive equipment to minimize the risks related to falls and implement interventions. The facility failed to ensure an environment free from accident hazards for R15. This deficient practice placed R15 at risk for preventable accidents and injuries.

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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. 45668 The facility identified a census of 54 residents. The sample included 14 residents with four residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R)25 had a documented safety assessment for the use of side rails that addressed entrapment, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the R25 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. Findings Included: - The Medical Diagnosis section within R25's Electronic Medical Records (EMR) noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder), spondylosis (degeneration of the vertebral column, and compression fracture of the vertebrae (broken bone of the spinal column). R25's Annual Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated he was dependent on staff for assistance with bathing, dressing, toileting, personal hygiene, and transfers. The MDS noted he required partial to moderate assistance with bed mobility. The MDS noted he had one injury fall since admission. The MDS indicated he had no restraints or bed rails in use. R25's Falls Care Area Assessment (CAA) completed 05/28/24 indicated he was at risk for falls related to his medical diagnoses. The CAA noted he had a history of wandering. The CAA noted he made his needs known but his cognitive status was expected to decline due to his Alzheimer's disease. R25's Care Plan initiated on 06/08/23 indicated he required staff assistance with his activities of daily living (ADLs). The plan indicated he was at risk for falls related to his medical diagnoses. The plan instructed staff to ensure his call light remained within reach and for staff to encourage him to use it. The plan indicated he used a bed cane to help with transfers and bed mobility. R25's EMR under evaluations revealed a Quarterly Assessment completed on 08/14/24. The assessment included a Bed Mobility Device evaluation that indicated R25 had a bed cane that enabled his mobility. The evaluation noted he had a left-side bed cane that enabled his bed mobility but did not impair his ability to get out of his bed. R25's EMR lacked a safety assessment for the use of his bed cane which addressed the risk of entrapment between the device and the mattress, a consent for the use, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the bed canes. The facility was unable to provide this documentation as requested on 08/29/24. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 08:05 AM R25 rested in his bed. R25 lay on his left side. R25 reported he had minor pain in his lower back and was ready for breakfast. R25's bed had a left-side bed cane (side rail) and R25 reported he used it to reposition himself but required staff assistance. On 08/29/24 at 10:20 AM Licensed Nurse (LN) G stated bed rails were assessed quarterly and upon application. She stated she was not sure if the documentation reflected risks associated with entrapment or the type of mattresses used. She stated most of the bed rails were left in the down position when applied and used as needed. She stated staff were expected to make sure no gaps were in between the mattress and the railing. On 08/29/24 at 10:35 AM Administrative Nurse D stated R25 had a bed cane installed and the facility did not assess bed canes as they would side rails. She stated R25's quarterly assessment indicated he had a bed cane, and it was not a restraint to him. She stated the facility would not complete consent or assess entrapment risks for the bed canes. The facility's Bed Mobility Device policy revised 11/2017 indicated all bed mobility devices that included side rails, bed canes, transfer poles, trapezes, and repositioning devices would be properly assessed for appropriate indication and safe use. The facility failed to ensure that R25 had a documented safety assessment for the use of side rails that addressed entrapment, a consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the R25 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41713 The facility identified a census of 54 residents. The sample included 14 residents. Based on record review and interview, the facility failed to ensure daily posted nurse staffing data included the facility census. Findings included: - Daily staffing hour sheets were requested from the past 18 months. The daily staffing sheets reviewed from 01/01/24 to 08/01/24 lacked the daily facility census number. On 08/29/24 at 10:31 AM, Administrative Nurse D stated she had tried a couple of different methods for making sure the daily posted nursing hours were completed which included the census number on them. Administrative Nurse D stated she had realized that the facility had still not been getting them completed. Administrative Nurse D stated she had appointed the responsibility of completing the daily posted staffing hours to the night charge nurse. The Daily Nurse Staff Posting policy revised on November 28, 2017, documented: At the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel who provided direct care to the residents would be posted using the Daily Nurse Staffing Form. Shift posting information would include only the number of full-time equivalents on duty for that day for that shift. Daily postings would be recorded on each facility's Daily Nurse Staffing Form, which would be retained for 18 months. The facility failed to ensure daily posted nurse staffing data included the facility census.

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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. 45668 The facility identified a census of 54 residents with one kitchen and three dining rooms. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to the storage of cookware, dishware, and food. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns. Findings Included: - A walkthrough of the facility's kitchen completed on 08/27/24 at 07:04 AM revealed the following: The dishware storage rack revealed plates, open salt/pepper shakers, and a cake pan stored uncovered and upward. The kitchen's ice machine scoop was stored directly on top of the ice machine without a barrier or sanitary container. The reach-in refrigerator had two opened but undated one-quart box containers of apple juice. The kitchen's brewing station had an uncovered metal tin container of tea left open to the air. The facility walk-in freezer's air condenser unit leaked condensation ice onto eight 3-gallon containers of ice cream. On 08/29/24 at 10:59 AM, Dietary Staff BB stated the plates and dishware should be stored facing downward. He stated staff were expected to date and label all food products as it's opened. He removed the ice cream containers and stated the walk-in freezer would be inspected. The facility's Storage Guidelines policy revised 11/2017 indicated the facility will ensure all food and supplies will be stored appropriately to ensure quality and maximize the safety of the food. The facility failed to follow sanitary dietary standards related to the storage of cookware, dishware, and food. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41037 The facility identified a census of 54 residents. The sample included 14 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to obtain consent or declinations for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Resident (R) 2, R15, and R37. This placed the residents at increased risk for complications related to pneumonia. Findings included: - A review of R2's clinical record revealed the Pneumococcal Conjugate Vaccine 13 (PCV13) was administered on 10/14/19 and the Pneumococcal Polysaccharide Vaccine 23 (PPSV23) required consent. R2's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. A review of R15's clinical record revealed the PCV13 was administered on 09/30/15 and the PPSV23 was administered on 09/18/17. R15's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. A review of R37's clinical record revealed the PCV13 was administered on 05/09/18 and the PPSV23 was administered on 11/04/19. R37's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. Upon request for R2's declination or administration of the PCV20 vaccine, the facility provided an updated consent form. Upon request for R15's declination or administration of the PCV20 vaccine, the facility provided a consent form dated 08/28/24. Upon request for R37's declination or administration of the PCV20 vaccine, the facility provided a consent form dated 08/28/24. On 08/28/24 at 10:45 AM Administrative Nurse D, the facility Infection Preventionist, stated she was the person responsible for tracking resident's immunizations. Administrative Nurse D stated she tracked the resident's immunizations on a spreadsheet. Administrative Nurse D stated she had spoken with R2's family representative and had received verbal consent to administer the PCV20. Administrative Nurse D stated she had left a message for R15's family representative for consent or declination for the PCV20. Administrative Nurse D stated R37 consented to receive the PCV20. Administrative Nurse D stated R2 and R37 would receive the immunizations when delivered from the pharmacy. The facility's Immunizations: Pneumococcal policy last revised 11/2017 documented that pneumococcal vaccinations would be offered to all residents per Centers for Disease Control and Prevention (CDC) guidelines. At the time of admission, the resident, resident representative, or attending physician would be contacted to obtain a history of previous pneumococcal vaccination. (continued on next page)

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	175533	A. Building B. Wing	08/29/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to offer PCV20 or obtain informed declinations for R2, R15, and R37 who were eligible to receive the vaccination. This placed R2, R15, and R37 at increased risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease.