STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175567	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan County Senior Living Inc	615 Price Ave Oakley, KS 67748

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 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 27168 The facility had a census of 27 residents. The sample included 13 residents. Based on record review and interview the facility failed to ensure the residents received their mail on Saturdays. Findings included: - On 04/02/24 at 10:30 AM during the resident council meeting, the residents verbalized there was no mail delivery on Saturdays. On 04/02/24 at 11:15 AM, Activity Staff Z verified the administration staff would get the mail during the week from a mailbox outside the facility and the key to the mailbox was located in the nurse's station. On 04/02/24 at 11:20 AM, Administrative Staff A verified the Administration staff would get the mail during the week from the mailbox in front of the facility, then the Social Service staff would deliver the mail to the residents. Administrative Staff A verified the key to the mailbox was kept in the nurse's station. Administration Staff A verified she was not sure if the weekend staff knew they were to get the mail and deliver it to the residents on Saturdays, but she would inform them. The facility's Mail and Electronic Communication policy, dated May 2017 documented that residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, emails, and other electronic forms of communication confidentially. Mail will be delivered to the resident unopened. Mail and packages will be delivered to the resident within 24 hours of delivery on the premises or to the facility's post office box (including Saturday deliveries.) The facility failed to ensure the residents received their mail on Saturdays.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 27168 The facility had a census of 27 residents. The sample included 13 residents. Based on record review and interview, the facility failed to provide Resident (R)5, R19, and R79 or their representative, the accurate Centers for Medicare and Medicaid (CMS) Skilled Nursing Facility Advanced Beneficiary Notices (ABN) Form 10055. This placed the resident at risk of uninformed decisions about their skilled services. Findings included: - The Medicare ABN form 10055 informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an option for the beneficiary to receive specific services listed, and bill Medicare for an official decision on payment. The form stated 1) I understand if Medicare does not pay, I will be responsible for payment but can make an appeal to Medicare, (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for services, (3) I do not want the listed services. A review of the ABN provided to R5 revealed that R5 received form CMS-R-131 instead of CMS Form 10055. The resident's skilled services ended on 03/02/24. A review of the ABN provided to R19 revealed that R19 received form CMS -R-131 instead of CMS Form 10055. The resident's skilled services ended on 12/14/23. A review of the ABN provided to R79 revealed that R79 received form CMS -R-131 instead of CMS Form 10055. The resident's skilled services ended on 02/02/24. On 04/02/24 at 01:45 PM, Social Services X verified she provided R5, R19, and R79, and/or their representative, the CMS-R-131 form, and failed to provide the 10055 forms. On 04/02/24 at 01:55 PM, Administrative Staff A verified the facility provided the CMS-R-131 form to R5, R19, and R79, and/or their representative, and verified the facility was previously owned by the local hospital and was bought out by a new corporation. Administrative Staff A said the facility had only been Medicare certified for a few years and had been using that form but also said the facility would switch to the correct form. The Advanced Beneficiary and Medicare Non-Coverage Notices policy, dated September 2022, documented that residents were informed in advance when changes would occur to their bills. The facility issues the Skilled Nursing Facility Advance Beneficiary Notices (CMS form 10055). The facility failed to provide R5, R19, and R79 or their representatives, the correct 10055 form which included an estimated cost of continued services when discharged from skilled care. This placed the residents at risk of uninformed decisions about their services and the continuation of their skilled services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 27 residents. The sample included 13, with two reviewed for dementia (progressive mental deterioration characterized by confusion and memory failure) care. Based on observation, record review, and interview, the facility failed to develop and implement an individualized dementia treatment plan for Resident (R)22, who had dementia and behaviors. This placed the resident at risk for abuse and decreased quality of life. Finding included: - R22's Electronic Medical Record (EMR) documented diagnoses of dementia without behavioral disturbance, mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), and pain. The Admission Minimum Data Set (MDS), dated [DATE], documented R22 had moderately impaired cognition. R22 required set-up assistance with toileting, eating, dressing, and personal hygiene, and was independent with mobility and transfers. The assessment further documented R22 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and had no behaviors. The Quarterly MDS, dated [DATE], documented R22 had severely impaired cognition. R22 required set-up assistance with personal hygiene and was independent with toileting, transfers, and mobility. The assessment further documented R22 received antipsychotic medications and had no behaviors. R22's Care Plan, dated 03/07/24 and initiated on 11/16/23, directed staff to administer medications as ordered, and communicate R22's capabilities with the resident, family, and caregivers. The plan directed staff to cue, reorient, and supervise as needed, and document any changes in R22's cognitive function. The plan lacked an individualized dementia treatment plan or guidance for staff when R22 had behaviors. The Physician's Order, dated 11/16/23, directed staff to administer Risperdal (an antipsychotic medication), 0.5 milligrams (mg) by mouth daily for the diagnosis of psychosis (any major mental disorder characterized by gross impairment in perception). This medication was discontinued on 02/14/24. The Physician's Order, dated 11/22/23, directed staff to monitor for behaviors. The Physician's Order, dated 01/18/24, directed staff to contact t Service to evaluate and treat for psychiatric and psychological needs. The Physician's Order, dated 02/17/24, directed staff to decrease the Risperdal medication to 0.25 mg daily for seven days and then discontinue. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 02/17/24, directed staff to administer Zoloft (an antidepressant medication), 25 mg for seven days then increase to 50 mg for the diagnosis of depression. The Physician's Order, dated 02/24/24, directed staff to administer Depakote (an anticonvulsant also used to treat mood disorders), 125 mg twice per day for the diagnosis of depression with psychotic symptoms. The Nurse's Note, dated 12/29/23 at 08:57 AM, documented R22 smacked a Certified Nurse Aide's (CNA) buttocks and made an inappropriate remark about the size of her buttocks. The Nurse's Note, dated 12/30/23 at 12:00 PM, documented R22 was verbally aggressive with another resident after a resident made a remark about R22's wife. The kitchen staff thought the verbal altercation might come to blows. The Nurse's Note, dated 03/03/34 at 06:22 PM, documented R22 slapped a CNA on the buttocks after she served his drinks and turned away. The note further documented the CNA asked R22 not to do that again and he asked her if she wanted a kiss as a reward for the drinks; the staff stated No and walked away. On 04/002/24 at 08:00 AM, observation revealed R22 at the dining table waiting for breakfast. R22 did not exhibit any behaviors. On 04/04/24 at 08:40 AM, Certified Medication Aide (CMA) R stated R22 yelled shut up at another resident who was loud but also said R22 had no other behaviors towards her. CNA R further stated if R22 had any behaviors toward her, she would tell him that it was not appropriate and tell the charge nurse. On 04/04/24 at 09:00 AM, Licensed Nurse (LN) G stated R22 had sexually inappropriate behaviors towards staff and recently started to see a physician through web-based mental health provider; he still had behaviors. On 94/04/24 at 1:00 PM, Administrative Nurse D verified R22's Care Plan did not have person centered interventions for R22's dementia behaviors and stated staff redirected R22 when he was inappropriate. The facility's Care Plans, Comprehensive Person-Centered policy, dated 03/22, documented a comprehensive, person-centered care plan would be developed to include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The interdisciplinary team review and update the care plan if there was a significant change in the condition of the resident, when the desired outcome was met, when the resident had been readmitted to the facility from a hospital stay and at least quarterly in conjunction with the required quarterly MDS assessment. The facility failed to revise the care plan with person centered interventions for R22 who had dementia and behaviors. This placed R22 at risk for decreased quality of life 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 27 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to staff followed acceptable standard of practice related to wound care for Resident (R) 79, who had an infected wound. This placed the resident at risk for delayed healing and other complications. Findings included: - The Electronic Medical Record (EMR) for R79 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis is made or the body cannot respond to the insulin), Charcot arthropathy (a rare complication of diabetes-related neuropathy (nerve damage)), Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics), neuropathy, chronic kidney disease, stage three (mild to moderate damage to the kidneys and they are less able to filter waste and fluid out of your blood), and vascular insufficiency (improper function of the vein valves in the leg). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R79 had intact cognition. R79 required set-up assistance for eating, personal hygiene, and mobility. R79 was dependent on staff for toileting and transfers. R79 did not ambulate. The assessment further documented R79 had a diabetic ulcer (a serious complication caused by a combination of poor circulation, susceptibility to infection, and nerve damage from high blood sugar levels), cellulitis (skin infection caused by bacteria), and had dressings to his feet. R79's Care Plan, dated 02/01/24, initiated on 08/17/23, directed staff to float R79's heels on a pillow while lying in bed and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. The update, dated 03/13/24, documented R79 had a diabetic ulcer and directed staff to ensure appropriate protective devices were applied to affected areas. The plan documented R79 had a wound vacuum (vacuum-assisted closure of a wound is a type of therapy to help wounds heal) in place on the wound on his right heel after the area was surgically debrided (process of removing dead tissue from wounds) and directed to monitor blood sugar levels, monitor and document the size of the wound, monitor for infection, and keep skin clean and dry. The Physician's Order, dated 03/11/24, directed staff to change R79's right heel wound vacuum every Monday, Wednesday, and Friday. Cleanse the area with normal saline, pat dry, apply foam, secure with film, then cut a slit in the film cover with suctioning attachment; ensure a proper seal, and cover with another layer of film. The Physician's Order, dated 03/27/24, directed staff to send R79 to the hospital daily for ceftriaxone sodium (an antibiotic), 2 grams (gm), intravenous (IV-administered directly into the bloodstream via a vein), until 04/08/24, for right heel wound. The Physician's Order, dated 03/27/24, directed staff to send R79 to the hospital daily for Daptomycin (an antibiotic), 500 milligrams (mg), IV daily, until 04/08/24, for right heel wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/24 at 08:15 AM, observation revealed Administrative Nurse D moved several personal items off R79's bedside table and set the scissors and wound vacuum supplies on it but did not sanitize the table first. Further observation revealed Administrative Nurse D washed her hands, donned a clean gown and gloves, removed the tubing from the wound vacuum, and removed the old dressing and foam from the wound. Wearing the same gloves, Administrative Nurse D cleansed the wound with wound cleanser, did not change her gloves, and then placed the bottle directly on R79's bed with the nozzle on the bed. Continued observation revealed Administrative Nurse D removed her gloves, washed her hands, donned clean gloves, and cut the foam for the wound vacuum without sanitizing the scissors. She placed the foam into the wound, covered it with film, attached the wound vacuum tubing, and turned on the wound vacuum. Administrative Nurse D removed her gloves and immediately took the wound cleanser and scissors and laid them both inside R79's dresser drawer. Administrative Nurse D then washed her hands and sanitized the bedside table. On 04/02/24 at 08:30 AM, Administrative Nurse D verified she did not sanitize the bedside table before setting the clean supplies on it. Administrative Nurse D stated she should not have laid the wound cleanser on the resident's bed and acknowledged the potential for cross-contamination. The facility's Wound Care policy, dated 10/10, directed staff to assemble the equipment and supplies as needed, wipe nozzles, bottle tops, with alcohol before opening. Use a disposable cloth to establish clean field on resident's overbed table and place all items to be used during the procedure on the clean field and arrange the supplies so they can be easily reached. Place a disposable cloth next to the resident to serve as a barrier to protect the bed linen and other body sites. When finished with the dressing, remove the disposable cloth net to the resident and discard into the designated container, saturate the bedside table with alcohol, wipe reusable supplies with alcohol as indicated, such as outsides of containers that were touched by unclean hands, scissor blades and return them to the resident's drawer in the treatment cart. The facility failed to staff followed acceptable standard of practice related to wound care for R79, who had an infected wound. This placed the resident at risk for delayed healing and other complications.

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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 32360

The facility had a census of 27 residents. The sample included 13 residents, with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure the environment was free of accident hazards for two sampled residents, Resident (R) 9, and R18, when the facility failed to assess the residents to safely use an electric wheelchair or to safely smoke. This placed the residents at risk for preventable accidents and injury.

Findings included:

- The Electronic Medical Record (EMR) documented R9 had diagnoses of diabetes mellitus type two (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (high blood pressure), and weakness.

The Quarterly Minimum Data Set (MDS), dated [DATE], documented R9 a Brief Interview for Mental Status score (BIMs) of 11, which indicated moderately impaired cognition. R9 required set-up assistance with toileting, dressing, and personal hygiene, and was independent with mobility and transfers. The assessment documented that R9 used a wheelchair for mobility. R9 had no impairments of the upper or lower extremities.

R9's Care Plan, dated 01/25/24 and initiated on 01/15/24, documented that R9 used a wheelchair for locomotion throughout the facility. R9 was able to independently propel himself and had an electric wheelchair. The plan directed R9 must have a footrest to place his feet on. The update, dated 03/11/24, documented R9 was unsafe at times with his electric wheelchair and directed staff to use the manual wheelchair due to R9's confusion or unsafe actions.

R9's EMR lacked documentation the facility assessed R9's ability to safely operate the electric wheelchair before R9's use of the chair in the facility.

The Physician's Order, dated 03/11/24, directed staff to monitor R9 for unsafe electric wheelchair use.

The Physician's Order, dated 03/12/24, directed staff to have Physical Therapy (PT) evaluate and treat for physical deconditioning and unsafe transportation in an electric wheelchair.

The Nurse's Note, dated 02/05/24 at 10:00 AM, documented R9 ran over R22's feet with his electric wheelchair. R22 got mad and there was a fight between the two residents. A family member alerted staff and asked for assistance to separate the two residents.

The Nurse's Note, dated 02/07/24 at 01:45 PM, documented R9 came down the hallway in his electric wheelchair and did not slow down until another resident was right in front of him. R9 yelled for the resident to get out of his way.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note, dated 02/10/24 at 03:15 PM, documented R9 was confused, leaning in his electric wheelchair, and running into furniture. R9 did not remember how to turn it off. The note further documented R9's confusion occurred daily and R9 could not be redirected. The Nurse's Note, dated 02/11/24 at 05:12 PM, documented R9 continued to increase in confusion and needed more assistance from staff drove up and down the halls in his electric wheelchair, bumped into doorways, the snack cart, and almost ran over a visitor. The Nurse's Note, dated 02/29/24 at 04:05 PM, documented R9 was confused and could not figure out how to use his electric wheelchair or his electric recliner. The Nurse's Note, dated 03/11/24 at 09:50 AM, documented R9 was upset and yelled at the nurse that he wanted his electric wheelchair back; R9 said was told it was broken and that maintenance would work on it but when he talked to maintenance, they were unaware what was going on with it. The note documented the nurse told R9 that he had been confused and had not controlled the electric wheelchair very well; he ran into walls, got his foot caught, and ran into lifts. R9 was upset and asked why they told him it required work on it instead of being told he had been confused and the nurse stated they felt the white lie was better than making the resident upset. R9 stated he would give them one week and if he did not get the wheelchair back, he would call his lawyer and press charges. Staff reminded R9 that he was able to move around the facility in his manual wheelchair but R9 stated that he could not get around as fast in the manual wheelchair. On 04/03/24 at 03:14 PM, observation revealed R9 sat in a manual wheelchair in the hallway most of the day and was friendly with staff. On 04/03/24 at 08:50 AM, Certified Medication Aide (CMA) R stated R9 had advanced cancer which caused him to become confused and he would run into mechanical lifts, and courtesy carts, and he ran over another resident's feet. CMA R further stated R9 drove down the hall so fast that he turned into another resident's room, who was in the dying process, and almost ran over a family member. On 04/03/24 at 09:00 AM, Licensed Nurse (LN) G stated R9 was rude to the CNA staff and had been confused. LN G said R9 tried to use his television remote to work the electric wheelchair so it was taken away. On 04/03/24 at 01:00 PM, Administrative Nurse D stated the facility had not completed a safety assessment for R9 when he got his electric wheelchair and because of his increased confusion, he was getting physical therapy. The facility's Assistive Devices and Equipment policy, dated 01/20, documented the facility maintained and supervised the use of assistive devices and equipment for residents. Certain devices and equipment that assist with resident mobility, safety, and independence are provided for residents, these may include mobility devices (wheelchairs, walkers, and canes), and recommendations for the use of the devices and equipment are based on the comprehensive assessment and documented in the resident medical record. The resident, family, and visitors are trained as indicated on the safe use of equipment and devices. The residents are assessed for lower extremity strength, range of motion, balance, and cognitive abilities when determining the safest use of devices and equipment. (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 ensure the environment was free of accident hazards for R9, who was unsafe on his electric scooter. This placed the resident at risk for injury. - R18's Electronic Medical Record (EMR) documented diagnoses of nicotine dependence (when you need nicotine, the chemical in tobacco that makes it hard to quit), diabetes mellitus type two (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), edema (swelling resulting from an excessive accumulation of fluid in the body tissue), and chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R18 had intact cognition and was independent with toileting, dressing, personal hygiene, mobility, and transfers. The assessment revealed R18 did not have any functional impairment. R18's Care Plan, dated 04/01/24, initiated on 04/20/23, documented R18 required supervision while she smoked, and her smoking supplies were stored in the medication cart. R18's EMR lacked evidence the facility assessed R18 for safe smoking practices. The Nurse's Note, dated 01/10/24 at 09:38 PM, documented R18 was upset and accused staff of not wanting to take her out to smoke, called the nurse a derogatory name, went to her room, and slammed the door. The Nurse' Note, dated 02/08/24 at 09:23 PM, documented that at 06:15 PM, R18 yelled at staff to go out and smoke because she could not wait until 07:00 PM for a cigarette. Staff explained to R18 that the scheduled time to smoke was 07:00 PM and R18 yelled that it only took five seconds to get her a cigarette and take her out. R18 went back to her room and slammed the door. The Nurse's Note, dated 03/26/24 at 03:09 AM, documented that during the evening shift, R18 wanted to go outside for a cigarette and became angry when staff would not take her out due to the rain, snow, and wind. On 04/04/24 at 09:00 AM, observation revealed R18 outside with a staff member, smoking a cigarette. On 04/03/24 at 09:48 AM, Certified Nurse Aide (CNA) M stated R18 was taken outside to smoke five times a day, at 07:00 AM, 09:00 AM, 01:00 PM, 08:00 PM, and 10:00 PM. CNA M said R18 would often get mad at staff if they could not take her outside due to the weather. CNA M stated if it was colder than 32 degrees, staff would not take R18 outside. On 04/03/24 at 01:45 PM, Administrative Nurse D verified a smoking assessment for R18 was not completed. Administrative Nurse D said R18 would get angry if the staff did not take her outside when she wanted to go smoke. (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's Smoking Policy, dated 10/23, documented the facility has established and maintained safe resident smoking practices. Before and upon admission, the resident was informed of the facility's smoking policy, which is located outside of the building, and smoking was not allowed inside the facility under any circumstances. The resident's smoking status was evaluated upon admission of the current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, and ability to smoke safely with or without supervision. The resident's ability to smoke safely was reevaluated quarterly, upon a significant change, and as determined by the staff. The facility failed to evaluate R18 for safe smoking practices. This placed R18 at risk for preventable accidents and related injury.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 27 residents. The sample included 13 residents with nine reviewed for mood and behavior. Based on observation, record review, and interview, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R)2. This placed her at risk for impaired quality of life due to untreated and ongoing mental health concerns. Findings - R2's Electronic Health Record (EHR) revealed diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R2's Admission Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident had a mood score of 16 which indicates moderate to severe depression. The MDS further indicated the resident had thoughts of being better off dead or of hurting herself. R2's Care Plan, dated 03/04/24 documented the resident had depression and was at risk for lack of hope for the future, changes in mood, sadness, and impaired concentration due to depression and schizophrenia disorder bipolar type. The care plan documented that staff would administer R2's medication as ordered and monitor and document for side effects and effectiveness. The facility would arrange for a psychiatric consult with follow-up as needed. The care plan directed staff to monitor and report any risk for self-harm, suicidal plan, past attempts at suicide, risky actions, intentional self-harm or attempts for self-harm, refusing to eat or drink, refusing medications and therapies, a sense of hopelessness or helplessness, impaired judgment, or safety awareness. The care plan directed staff to remove the resident to a calm safe environment and allow her to vent her feelings when conflict arises. The Social Services Notes, dated 02/23/24 at 09:40 AM, documented the resident stated she was feeling down and hopeless and she felt this way every day. The social service note documented the resident stated she was currently on medication for depression. R2's clinical record revealed lacked evidence or documentation from social service staff regarding resident statements or her behaviors. R2's clinical record lacked psychotherapy notes or evidence of mental health services. On 04/01/24 at 04:00 PM, observation revealed R2 sat in her recliner, watching TV, dressed in a nightgown. Her hair was scraggly and uncombed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan County Senior Living Inc	615 Price Ave Oakley, KS 67748

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 12:50 PM, Administrative Staff A verified the documentation on the Admission MDS indicating the resident felt she would be better off dead or hurting herself. Administrative Staff A verified the section of the MDS was completed by the Social Service Designee (SSD) and she nor the Director of Nursing were informed that R2 had said that or felt that way. Administrative Staff A verified the SSD should convey the information to the charge nurse and the charge nurse would assess the resident and notify the physician; the staff would alert the Administrator and the DON and further action would be taken to provide care for the resident and keep her safe until further treatment as needed. The facility's, Suicide Threats policy, dated December 2007, documented resident suicide threats shall be taken seriously and addressed appropriately. Staff shall report any resident threats of suicide immediately to the Nurse Supervisor or Charge Nurse. The Charge Nurse would immediately assess the situation and shall notify the Charge Nurse and/or Director of Nursing of such threats. A staff member shall stay with the resident until the Nurse Supervisor arrives to evaluate the resident. After assessing the resident in more detail, the Nurse Supervisor shall notify the resident's attending physician and responsible party and shall seek further direction from the physician. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update the care plan accordingly, until a physician has determined that a risk of suicide does not appear to be present. Staff shall determine details of the situation objectively in the resident's medical record. The facility failed to assess, monitor, and provide mental health services for R2 after R2 verbalized she would be better off dead or had thoughts of self-harm. This deficient practice placed her at risk for impaired quality of life due to untreated and ongoing mental health concerns.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 27 residents. The sample included 13, with two reviewed for dementia (progressive mental deterioration characterized by confusion and memory failure) care. Based on observation, record review, and interview, the facility failed to develop and implement an individualized dementia treatment plan for Resident (R)22, who had dementia and behaviors. This placed the resident at risk for abuse and decreased quality of life. Finding included: - R22's Electronic Medical Record (EMR) documented diagnoses of dementia without behavioral disturbance, mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), and pain. The Admission Minimum Data Set (MDS), dated [DATE], documented R22 had moderately impaired cognition. R22 required set-up assistance with toileting, eating, dressing, and personal hygiene, and was independent with mobility and transfers. The assessment further documented R22 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and had no behaviors. The Quarterly MDS, dated [DATE], documented R22 had severely impaired cognition. R22 required set-up assistance with personal hygiene and was independent with toileting, transfers, and mobility. The assessment further documented R22 received antipsychotic medications and had no behaviors. R22's Care Plan, dated 03/07/24 and initiated on 11/16/23, directed staff to administer medications as ordered, and communicate R22's capabilities with the resident, family, and caregivers. The plan directed staff to cue, reorient, and supervise as needed, and document any changes in R22's cognitive function. The plan lacked an individualized dementia treatment plan or guidance for staff when R22 had behaviors. The Physician's Order, dated 11/16/23, directed staff to administer Risperdal (an antipsychotic medication), 0.5 milligrams (mg) by mouth daily for the diagnosis of psychosis (any major mental disorder characterized by gross impairment in perception). This medication was discontinued on 02/14/24. The Physician's Order, dated 11/22/23, directed staff to monitor for behaviors. The Physician's Order, dated 01/18/24, directed staff to contact t Service to evaluate and treat for psychiatric and psychological needs. The Physician's Order, dated 02/17/24, directed staff to decrease the Risperdal medication to 0.25 mg daily for seven days and then discontinue. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 02/17/24, directed staff to administer Zoloft (an antidepressant medication), 25 mg for seven days then increase to 50 mg for the diagnosis of depression. The Physician's Order, dated 02/24/24, directed staff to administer Depakote (an anticonvulsant also used to treat mood disorders), 125 mg twice per day for the diagnosis of depression with psychotic symptoms. The Nurse's Note, dated 12/29/23 at 08:57 AM, documented R22 smacked a Certified Nurse Aide's (CNA) buttocks and made an inappropriate remark about the size of her buttocks. The Nurse's Note, dated 12/30/23 at 12:00 PM, documented R22 was verbally aggressive with another resident after a resident made a remark about R22's wife. The kitchen staff thought the verbal altercation might come to blows. The Nurse's Note, dated 03/03/34 at 06:22 PM, documented R22 slapped a CNA on the buttocks after she served his drinks and turned away. The note further documented the CNA asked R22 not to do that again and he asked her if she wanted a kiss as a reward for the drinks; the staff stated No and walked away. On 04/002/24 at 08:00 AM, observation revealed R22 at the dining table waiting for breakfast. R22 did not exhibit any behaviors. On 04/04/24 at 08:40 AM, Certified Medication Aide (CMA) R stated R22 yelled shut up at another resident who was loud but also said R22 had no other behaviors towards her. CNA R further stated if R22 had any behaviors toward her, she would tell him that it was not appropriate and tell the charge nurse. On 04/04/24 at 09:00 AM, Licensed Nurse (LN) G stated R22 had sexually inappropriate behaviors towards staff and recently started to see a physician through web-based mental health provider; he still had behaviors. On 94/04/24 at 1:00 PM, Administrative Nurse D verified that R22's Care Plan did not have person-centered interventions for R22's dementia behaviors and stated staff redirected R22 when he was inappropriate. The facility's Dementia policy, dated 11/18, documented the individual confirmed with dementia, the interdisciplinary team would identify a resident-centered care plan to maximize remaining function and quality of life, and the nursing assistance team would receive initial training in the care of residents with dementia and related behaviors. In-services would be conducted at least annually thereafter. The policy further documented the physician would order appropriate interventions to address significant behavioral and psychiatric symptoms based on pertinent clinical guidelines and consistent with regulatory requirements. The facility failed to develop and implement individualized interventions and/or a dementia treatment plan for R22 who had dementia and behaviors. This deficient practice placed the resident at risk for abuse and decreased quality of life.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 27 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician of out-of-parameter blood sugars for one resident, Resident (R) 18. This placed the resident at risk for unnecessary medication side effects and other related complications. Findings included: - The Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus type two (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), edema (swelling resulting from an excessive accumulation of fluid in the body tissue), and chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R18 had intact cognition and was independent with toileting, dressing, personal hygiene, mobility, and transfers. The assessment revealed R18 received hypoglycemic (low blood sugar) medication. R18's Care Plan, dated 04/01/24, initiated on 04/20/23 directed staff to avoid exposure to extreme heat or cold, check the body for breaks in the skin, and treat promptly as ordered by the physician. The plan directed staff to administer diabetes medication as ordered by the physician and document for side effects and effectiveness. The Physician's Order, dated 12/30/22, directed staff to obtain R18's blood sugar daily at bedtime. The order was discontinued on 03/26/24. The Physician's Order, dated 06/27/23, directed staff to notify the physician if R18's blood sugar was less than 70 milliliters (ml) per deciliter (dL) or greater than 170 milliliters dL. The Physician's Order, dated 03/26/24, directed staff to obtain R18's blood sugar every Monday and Thursday for the diagnosis of diabetes mellitus type two. R18's Treatment Administrative Record, dated February 2024, documented the following days R18's blood sugar was out of parameters and the physician was not notified. 02/03/24-178 mm/dL 02/07/24-176 mm/dL 02/17/24-235 mm/dL 02/20/24-219 mm/dL (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/29/24-180 mm/dL R18's Treatment Administrative Record, dated March 2024, documented the following days R18's blood sugar was out of parameters and the physician was not notified. 03/09/24-202 mm/dL 03/12/24-181 mm/dL 03/18/24-202 mm/dL 03/19/24-214 mm/dL 03/22/24-179 mm/dL On 04/01/24 at 04:00 PM, observation revealed R18 ambulated with her walker into the dining room. On 04/03/24 at 01:45 PM, Administrative Nurse D verified the physician was not notified of the out-of-parameter blood sugars. On 04/04/24 at 09:00 AM Licensed Nurse (LN) G stated she would notify the doctor if the resident's blood sugar was over 400 mm/dL and verified the Treatment Administration Record did not indicate what the blood sugar parameters were for R18. The facility's Diabetes Clinical Protocol, dated 11/20, documented as part of the initial assessment, the physician would help identify individuals with elevated blood sugar, impaired glucose tolerance, or confirmed diabetes, as well as factors that may influence glucose intolerance, the physician would order desired parameters for monitoring and reporting information related to blood sugar management. The facility failed to notify the physician when R18's blood sugar was out of the physician-ordered parameters. This placed the resident at risk for unnecessary medication side effects and other related complications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 27 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to date Resident (R)11's insulin (a hormone that allows cells throughout the body to uptake glucose) flex pen. This deficient practice placed the resident at risk for ineffective medications. Findings included: - On [DATE] at 10:30 AM, observation revealed R11's Levemir (long-acting insulin) flex pen lacked an open date. On [DATE] at 10:35 AM, Licensed Nurse (LN) H verified the nurses were to date the flex pens when opened and discard the insulin pen when expired. On [DATE] at 04:00 PM, Administrative Nurse E verified the nurses should label and date the flex pens with the resident's name and discard expired and/or outdated pens. According to www.Medlineplus.gov, Levemir pens can be used within 42 days, but after that time they must be discarded. The facility's Insulin Administration policy, dated [DATE], documented the facility would provide safe administration of insulin to residents with diabetes. The type of insulin, dosage requirements, strength, method of administration, and blood sugar parameters must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. The nurse would check the expiration date The facility failed to dispose of an outdated insulin flex pen for R11 placing the resident at risk for ineffective medication.

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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** 27168 The facility had a census of 27 residents. The sample included 13 residents with one 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)3. This placed R3 at risk for inappropriate end-of-life care. Findings included: - R3's Electronic Health Record (EHR) revealed diagnoses of heart failure (a condition with low heart output and the body becomes congested with fluid), abnormal weight loss, stage 3 kidney disease (mild to moderate damage and they are less able to filter waste and fluid from your body), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance. R3's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R3 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS failed to document the resident received hospice services. R3's Care Plan, dated 03/07/24, recorded R3 required extensive assistance with most activities of daily living (ADL) care. R3's Care Plan documented there was a holistic (treating someone as mind and body, instead of treating only the part of the body that is the sickest) approach to resident care by collaboration between hospice and nursing facility staff. A review of R3's Care Plans revealed the resident was admitted to hospice care on 03/07/24 but lacked evidence of coordination of care between hospice and the facility. The facility had not received the hospice care plan from hospice, so the hospice care plan was not available to review in the EHR. The review revealed there was no communication book or external document. On 04/01/24 at 04:00 PM, observation revealed R3 sat in a recliner in her room hollering. Staff went into the resident's room and assisted her in standing with two staff using a gait belt. Staff assisted her to the commode in her room, assisted with toileting activity, and then assisted her back to the room following peri care. On 04/02/24 at 04:05 PM, Administrative Staff A stated she expected the facility to have a hospice care plan for R3 to be able to coordinate care with hospice services. Administrative Staff A verified the facility lacked a hospice care plan for R3 since her admission to hospice 03/07/24. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice Program policy, dated July 2017, documented the hospice contractor who contracts with the facility must have a written agreement outlining in detail the responsibilities of the facility and the hospice agency and are held responsible for meeting the same professional standards and timelines of services as any contracted individual or agency associated with the facility. The responsibility of hospice is to manage the resident's care as it relates to the terminal illness and related conditions. The facility would coordinate care provided to the resident by the facility staff and the hospice staff. Coordinated care plans for residents receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility (including the responsible provider and discipline assigned to specific tasks) to maintain the resident's highest practicable physical, mental, and psychosocial well-being. The coordinating care plan shall be revised and updated as necessary to reflect the resident's status including, but not limited to diagnosis, problem list, symptom management, bowel and bladder care, nutrition and hydration, oral health, skin integrity, spiritual, activity and psychosocial needs, and mobility and positioning. The facility failed to coordinate care between the facility and the hospice provider for R3, who received hospice services. This deficient practice placed her at risk for inappropriate end-of-life care.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 27168 The facility had a census of 27 residents. Based on record review and interview, the facility failed to submit complete and accurate staffing information through Payroll Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2023 Quarter 2 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on following days: 01/03/23, 01/13/23, 01/14/23, 01/16/23, 01/19/23, 01/26/23, 01/27/23, 01/29/23. 02/02/23, 02/06/23, 02/12/23, 02/14/23, 02/16/23, 02/23/23, 02/25/23, 02/26/23, 03/12/23, 03/26/23. The PBJ report for FY 2023 Quarter 3 indicated no licensed nurse coverage on 04/09/23, 04/21/23, 05/04/23, 05/06/23, 05/20/23, 05/21/23, 05/29/23, 06/10/23 and 06/11/23. The PBJ report for FY 2023 Quarter 4 indicated no licensed nurse coverage on 08/13/23, 08/20/23, 08/26/23, 08/27/23, 08/28/23, 09/02/23, 09/03/23, 09/17/23, 09/22/23, 09/23/23, 09/24/23, and 09/30/23. Review of the facility licensed nurse payroll data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 04/02/24 at 11:30 AM, Administrative Staff A verified the facility submitted accurate nursing hour data for the PBJ, however the corporate staff that would input the data failed to document the correct hours, and the corporation has a new employee that is currently submitting the data. She verified the nurse clock in hours and nurse coverage on all the days. The facility's Staffing, Sufficient and Competent policy, dated August 2022 documented the facility provides enough nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with residents' care plans and the facility assessment. License nurses and certified assistants are available 24 hours a day, 7 days a week to provide competent resident care and services . A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (&) days a week. RN's may be scheduled more than 8 hours depending on the acuity of needs of the residents. Licensed nurses are required to supervise nurse's aide and nursing assistants and are scheduled in such a way that permits adequate time to do so. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32360 The facility had a census of 27 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure adequate infection control measures for Resident (R) 79 before, during, and after wound care. This placed the resident at risk for continued wound infection, cross contamination, and other infectious disease. Findings included: - On 04/02/24 at 08:15 AM, observation revealed Administrative Nurse D moved several personal items off R79's bedside table and set the scissors and wound vacuum supplies on it but did not sanitize the table first. Further observation revealed Administrative Nurse D washed her hands, donned a clean gown and gloves, removed the tubing from the wound vacuum, and removed the old dressing and foam from the wound. Wearing the same gloves, Administrative Nurse D cleansed the wound with wound cleanser, did not change her gloves, and then placed the bottle directly on R79's bed with the nozzle on the bed. Continued observation revealed Administrative Nurse D removed her gloves, washed her hands, donned clean gloves, and cut the foam for the wound vacuum without sanitizing the scissors. She placed the foam into the wound, covered it with film, attached the wound vacuum tubing, and turned on the wound vacuum. Administrative Nurse D removed her gloves and immediately took the wound cleanser and scissors and laid them both inside R79's dresser drawer. Administrative Nurse D then washed her hands and sanitized the bedside table. On 04/02/24 at 08:30 AM, Administrative Nurse D verified she did not sanitize the bedside table before setting the clean supplies on it. Administrative Nurse D stated she should not have laid the wound cleanser on the resident's bed and acknowledged the potential for cross-contamination. The facility's Wound Care policy, dated 10/10, directed staff to assemble the equipment and supplies as needed, and wipe nozzles, and bottle tops, with alcohol before opening. Use a disposable cloth to establish a clean field on the resident's overbed table and place all items to be used during the procedure on the clean field and arrange the supplies so they can be easily reached. Place a disposable cloth next to the resident to serve as a barrier to protect the bed linen and other body sites. When finished with the dressing, remove the disposable cloth net from the resident and discard it into the designated container, saturate the bedside table with alcohol, and wipe reusable supplies with alcohol as indicated, such as the outsides of containers that were touched by unclean hands, scissor blades and return them to the resident's drawer in the treatment cart. The facility failed to ensure adequate infection control measures during wound care for R79, who had an infection in a wound. This placed the resident at risk for continued wound infection, cross contamination, and other infectious disease.