STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17A029	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Living Center	535 South Freeborn Marion, KS 66861

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 26 residents. The sample included 12 residents. Based on interviews, observation, and record review, the facility failed to ensure a safe, clean home-like environment in all areas of the facility including the resident rooms. Findings included:- Observed on 10/06/25 at 10:56 AM, several areas of Resident (R) 1's room walls had missing paint with exposed sheetrock. The bathroom door had multiple areas of missing paint with exposed wood and the metal door frame to the bathroom had missing paint with exposed metal.Observed on 10/06/25 at 11:28 AM, multiple areas on walls in R17's room had chipped and missing paint with exposed sheetrock. The bathroom door had paint missing in multiple areas with exposed wood and the bathroom door frame had missing paint with exposed metal.Observed on 10/06/25 at 11:36 AM, R2's bathroom door had multiple areas with exposed wood and the door frame had missing paint with exposed metal.Observed on 10/06/25 at 11:48 AM, R19's bathroom door had multiple areas of exposed wood, and the door frame had paint missing with exposed metal.Observed on 10/06/25 at 12:08 PM, R16's bathroom door and R4's bathroom door had multiple areas with exposed wood and the door frame had exposed metal.Observed on 10/06/25 at 12:32 PM, R5's bathroom door and door frame had multiple areas with exposed wood and metal.Observed on 10/07/25 at 09:00 AM, the public bathroom door had a large area of missing paint with exposed wood.Observed on 10/08/25 at 08:30 AM, during the facility walkthrough with Administrative Staff A and Administrative Nurse E, several areas of the walls had missing paint with exposed sheetrock. There were numerous ceiling tiles throughout the hallways that had brown water stains, and many were breaking and flaking, several were bulging and created open access to the drop-ceiling space above the tiles.Observed on 10/08/25 at 08:43 AM, the clean utility room had ceiling tiles around the ceiling A/C unit that had water stains, and several tiles were flaking and breaking. The wall molding of the countertop was pulling away from the wall and the wall by the sink had a large area that was scraped and had several exposed areas of sheetrock.Observed on 10/08/25 at 08:50 AM, a handrail on the Sunflower hallway had a large area, approximately one foot by four inches, that was scraped and had exposed wood and the ceiling tiles around the ceiling A/C unit at the Sunflower hallway intersection had large water spots and broken/flaking areas.On 10/08/25 at 08:45 AM, Administrative Staff A and Administrative Nurse E stated that he was unaware of the ceiling tiles, wall and molding issues in the clean utility room. They further stated that he was unaware of the ceiling tile issues in the resident apartments and hallways. Administrative Staff A then stated that maintenance repair/remodeling of resident apartments occurred when an apartment became vacant. Administrative Staff A then stated that he expected staff to be vigilant and report any maintenance or environmental concerns immediately.On 10/08/25 at 09:00 AM, Maintenance U stated that the wall and counter problem in the clean utility room had not been reported and he was unaware. He further stated ceiling tiles were replaced on a spot-check basis as they were noticed. Maintenance U also stated that apartment painting and remodeling occurred as apartments became vacant, other repairs occurred as they were reported, maintenance reports occurred through LIMBLE (a cloud-based CMMS computerized maintenance management system that functions as a maintenance (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reporting system by allowing users to submit work requests via a web portal or email, track work order status in real-time, and generate automated reports on asset performance, maintenance costs, and work order completion rates) that created a work order repair [NAME], this system also created a monthly preventative maintenance (PM) list.On 10/08/25 at 09:19 AM, Certified Medication Aide (CMA) R stated that maintenance and environmental concerns were reported to the charge nurse and submitted through LIMBLE. She further stated that concerns that would be submitted included light problems, bed problems, resident care equipment issues and plumbing problems.The facility policy Facility Repairs, dated 06/08/24, documented that all buildings, equipment, and infrastructure owned or managed by St. [NAME] Hospital and Living Center would be maintained in a safe, functional, and efficient condition. The policy further documented that plant operations would complete monthly rounds to identify any problems or concerns and to complete preventative maintenance.The undated facility policy Resident Rooms, documented that resident room spaces should reflect comfort, personal choice, accommodate and incorporate features of home.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility identified a census of 26 residents. The sample included 13 residents with five residents sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to inform R18 or her representative about the risk and benefits of taking an antianxiety (a class of medications that calm and relax people).Findings included:- R18's Electronic Medical Record (EMR) revealed the following diagnoses: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), psychotic disorder (a type of mental health illness characterized by a dissociation from reality, often involving symptoms such as delusions and hallucinations), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).R18's 07/09/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of four, indicating severely impaired cognition. The MDS documented R18 had no delusions, or hallucinations. R18 did wander one to three days during the seven days prior to the assessment. The MDS recorded R18 took antipsychotic, antidepressant (a class of medications used to treat mood disorders), antianxiety and opioid (a class of controlled drugs used to treat pain). R18's Psychotropic Drug Use CAA documented R18 took Buspar (an antianxiety medication) for the treatment of anxiety. R18's Care Plan documented R18 took Buspar three times a day for anxiety on 04/16/24.R18's Physician's Orders documented R18 took Buspar five milligrams three times a day for anxiety disorder; ordered on 01/23/25.Review of R18's Drug Regimen Reviews noted no requests for staff to obtain an informed consent from the resident's representative.R18's clinical record lacked evidence of informed consent regarding the Buspar. On 10/08/25 at 9:56 AM, R18 sat at the table eating a snack in the common area. Staff walked by and observed and addressed her as they walked by.On 10/07/25 at 11:37 AM, Licensed Nurse (LN) G stated that when residents received psychotropic medication, Administrative Nurse D got the consents from the resident and/or their resident representative. On 10/07/25 at 3:12 PM, Administrative Nurse E stated she looked everywhere and could not find an informed consent for the Buspar, and confirmed it was not documented in the notes that the Buspar was discussed with the resident or the representative.On 10/08/25 at 11:44 AM, Administrative Nurse D stated she got the informed consent from the resident/resident representative. She was unable to find the consent for R18's Buspar and could not find a note that it was discussed.The facility policy for Psychotropic Medication, undated, documented residents will be obtained prior to administration of any nonemergent psychotropic medications.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. The facility identified a census of 26 residents. The sample included 13 residents with five residents sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to attempt a gradual dose reduction (GDR) for Resident R)18's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), medication. Findings included:- R18's Electronic Medical Record (EMR) revealed the following diagnoses: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), psychotic disorder (a type of mental health illness characterized by a dissociation from reality, often involving symptoms such as delusions and hallucinations), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).R18's 07/09/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of four, indicating severely impaired cognition. The MDS documented R18 had no delusions, or hallucinations. R18 did wander one to three days during the seven days prior to the assessment. The MDS recorded R18 took antipsychotic, antidepressant (a class of medications used to treat mood disorders), antianxiety (a class of medications that calm and relax people), and opioid (a class of controlled drugs used to treat pain). The MDS documented no GDR for the antipsychotic was attempted, and the physician had not documented a GDR was contraindicated.R18's Psychotropic Drug Use CAA documented R18 took Seroquel (an antipsychotic medication) for the treatment of depression and mania. R18's Care Plan documented R18 took Seroquel at supper for anxiety and restlessness on 04/16/24.R18's Physician's Orders documented R18 took Seroquel 25 milligrams (mg) by mouth in the evening for psychotic disorder with delusions due to a known physiological condition; ordered on 05/11/24.Review of R18's Drug Regimen Reviews noted no requests for a GDR for the Seroquel.On 10/08/25 at 9:56 AM, R18 sat at the table eating a snack in the common area. Staff walked by and observed/ and addressed her as they walked by.On 10/07/25 at 11:37 AM, Licensed Nurse (LN) G stated that when residents received psychotropic medication, Administrative Nurse D got the consents from the resident and/or their resident representative. LN G stated Administrative Nurse D addressed the pharmacy recommendations.On 10/07/25 at 3:12 PM, Administrative Nurse E stated she looked everywhere and could not find that the pharmacist ever requested a GDR for R18's Seroquel. Administrative Nurse F confirmed there was no request for a GDR, no attempt for a GDR, and no risk versus benefits statement for the Seroquel.On 10/08/25 at 11:44 AM, Administrative Nurse D stated the pharmacist recommended GDRs when he completed his reviews but verified there was no recommendation for R18 to reduce the Seroquel. She said she was aware that it was a regulation to attempt GDRs unless it was contraindicated.The facility policy for Psychotropic Medication, undated, documented residents who were prescribed an antipsychotic medication shall receive gradual dose reductions per CMS requirements.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility reported a census of 26 residents. The sample included 13 residents with one resident reviewed for hospitalization. Based on interview and record review, the facility failed to provide Resident (R) 6 a written notification of transfer to the resident and/or his representative as soon as practicable and failed to send a copy of that notification to the ombudsman. The facility also failed to provide R6 or the responsible party with a bed hold. Findings included:- R6's Electronic Medical Record (EMR) revealed a diagnosis of heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively enough to meet the body's needs) and dementia (a progressive mental disorder characterized by failing memory and confusion).R6's EMR documented a Health Status Note dated 09/07/25 at 07:57 AM that documented R6 was short of breath with walking to the bathroom. R6 had wheezing and diminished breath sounds.R6's Health Status Note dated 09/07/25 at 11:05 AM, documented R6 was admitted to the hospital for observation. The hospital planned to take fluid off.R6's EMR lacked documentation of written notification to the resident and/or her representative, which explained the reason for the transfer to the hospital. The EMR lacked documentation that the bed hold was explained and given to R6 or her representative.On 10/07/25 at 11:37 AM, Licensed Nurse (LN) G stated that Social Services X gave the resident or the responsible party the bed hold when a resident went out to the hospital and the nurse verbally notified the family of transfers to the hospital.On 10/07/25 at 11:40 AM, Social Services X stated that she was the person that goes over the bed hold with the resident's representative. Social Services X noted that she forgot to do it on R6's transfer to the hospital. Social Services X said she was unaware of the regulation to notify the resident in writing and notify the ombudsman.On 10/07/25 at 11:48 AM, Administrative Nurse D stated the bed hold should be completed and signed by the next business day when a person transferred out of the facility. Administrative Nurse D said she was unaware of the regulation to notify the resident's representative in writing of a discharge or transfer and the facility had not been notifying the ombudsman.The facility's Resident Bed Hold for Admission policy dated 10/06/15 documented if there was a desire to hold the room the family would sign a bed hold agreement at the time of transfer.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 26 residents. The sample included 13 residents with two sampled for baseline care plan. Based on observation, interview, and record review, the facility failed to complete a baseline care plan for Resident (R) 29.Findings included:- R29's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion), failure to thrive, hypertension (HTN-elevated blood pressure), and atrial fibrillation (rapid, irregular heartbeat).R29 admitted on [DATE] so the 10/03/25 admission Minimum Data Set (MDS), was not completed.R29's Baseline Care Plan dated 09/25/25, was unsigned by R29 or his responsible party. It documented R29 was a full code (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest). It did not have the fall risk section completed. R29's Baseline Care Plan documented he had a behavior of wandering, including a previous incident of wandering outside of the house. It did not have the elopement section completed, which included a question on if he had a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering). The Social Service portion of the care plan was not completed, which included his plans for discharge or to stay long term. The care plan indicated he took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication) which was not correct.On 10/06/25 at 12:19 PM R29 sat at the dining room table in his wheelchair with a WanderGuard around his left ankle. R29 pushed himself backwards and wheeled himself back to his room.On 10/08/25 at 9:26 AM R29 laid diagonally on his bed with his feet hanging ff the bed. R29's left foot was on the mattress on the floor beside his bed. R29's bed was in a low position.On 10/07/25 10:40 AM, Certified Nurse Aide (CNA) M stated staff followed the care plans to know how to care for a resident.On 10/08/25 at 8:33 AM, Administrative Nurse F stated usually the charge nurse goes over the baseline care plan with the residents and the family, or the Assistant Director of Nursing (ADON) does it. Administrative Nurse F said R29's representative left early on the admission day, so staff were unable to do that with R29's representative. Administrative Nurse F confirmed staff did not call or attempt to do it another way.On 10/08/25 at 8:34 AM, Licensed Nurse (LN) G stated usually the nurse completed the baseline care plan and the charge nurse or the ADON went over it with the resident and/or the resident's representative.On 10/08/25 at 11:44 AM, Administrative Nurse D stated that the baseline care plan is part of the admission packet; the charge nurse fills it out and goes over it with the resident and the resident representative at the time of admission.The facility policy for Nursing Care Plan, undated, noted the facility will ensure that each resident has an individualized current care plan.

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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. The facility reported a census of 26 residents. The sample included 12 residents. Based on interviews, record reviews and observation, the facility staff failed to implement adequate and acceptable infection control practices when staff did not disinfect a glucometer (an instrument used to calculate blood glucose) after use.Findings included:- Observed on 10/07/25 at 11:22 AM, Licensed Nurse (LN) G perform a blood glucose check on Resident (R) 2 after performing hand hygiene and donning gloves. Upon completion of the blood glucose check LN G returned to the nurse's office and did not clean or disinfect the glucometer.On 10/07/25 at 11:30 AM, LN G verified that she did not clean the glucometer and further stated that she did not usually clean it unless there was blood on it, or it was dirty.On 10/08/25 at 11:44 AM, Administrative Nurse A stated that the facility educated staff on measuring blood glucose using glucometers every year as part of the yearly competencies, and she expected staff to clean and disinfect the glucometers after each use.The undated facility Infection Control for Living Center Residents documented that the policy was to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 26 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include the daily licensed and unlicensed staff actual hours.Findings included:- Daily Staffing sheets reviewed for the following dates did not list the actual hours worked, the total hours worked for nurses and CMA/CNA were listed: 08/01/25, 08/02/25, 08/03/25, 08/04/25, 08/05/25, 08/06/25, 08/07/25.Observed on 10/06/25 at 10:05 AM, the daily staffing sheet was not posted. Observed on 10/07/25 at 10:11 AM, the daily staffing sheet was posted on door frame of the nurse's office and only listed the total hours worked, the actual hours were not listed.ON 10/07/25 at 10:26 AM, Licensed Nurse (LN) G reported that the 3PM to 3AM shift was responsible for filling out the daily staffing sheets based on the weekly staffing schedule; that nurse then taped the staffing sheet to the door frame of the nurse's office.On 10/07/25 at 10:42 AM, Administrative Nurse A stated that the actual hours worked were not recorded at the end of each shift on the staffing sheet, she figured up the actual hours for the daily staffing sheets and did so once she received the invoices from the agency company the facility utilized for staffing needs. The facility policy St. [NAME] Living Center Staffing, dated 01/08/15, documented that the facility would designate a licensed nurse to serve as a charge nurse on each tour of duty and that the facility would staff licensed personnel 24/7 using Registered Nurses (RN) and Licensed Practical Nurses (LPN).