STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E026	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meade District Hosp Ltcu Dba Lone Tree Retirement	801 E Grant Meade, KS 67864

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility reported a census of 33 residents. The sample included 12 residents with two reviewed for dignity. Based on observation, interview and record review, the facility failed to treat residents in a dignified manner when Resident (R)4 received care without privacy. This deficient practice placed the resident at risk for decreased psychosocial well-being and embarrassment. Findings included:- R4's Electronic Health Record (EHR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (a progressive mental disorder characterized by failing memory and confusion). R4's 07/17/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The assessment documented R4 was dependent on staff for transfers. The 07/17/25 Cognitive Loss / Dementia Care Area Assessment (CAA) documented R4 had impaired cognitive function. The 07/17/25 ADL Functional / Rehabilitation Potential CAA documented R4 had a self-care performance deficit related to impaired balance, impaired coordination related to progression of Alzheimer's disease, and other medical conditions. Observation on 08/19/25 at 01:07 PM revealed Certified Nurse Aide (CNA) M went into R4's room with a mechanical lift and left the door to the hallway open, and the privacy curtain remained in the open position. CNA M pressed the call light for additional assistance, and while waiting for help, connected R4 to the mechanical lift. The procedure was fully visible from the hallway. At 08/19/25 at 01:09 PM, CNA N walked by R4's room, then went in and closed the door. During an interview on 08/19/25 at 01:20 PM, CNA M revealed the door and/or privacy curtain should have been closed to provide privacy and dignity for R4 when the resident was being connected to the mechanical lift. During an interview on 08/21/25 at 11:25 AM, Licensed Nurse (LN) G revealed when mechanical lifts are in use, or when connecting to a resident or resident's sling, the doors and privacy curtains should be closed to provide privacy and dignity for the residents. During an interview on 08/21/25 at 11:40 AM, Administrative Nurse D revealed doors should be closed and curtains drawn during every stage of mechanical lift use to provide privacy and dignity for the residents. The facility's Resident Rights policy, dated 01/10/25, documented all residents have the right to a dignified existence. The facility must protect and promote each resident's dignity and respect in all aspects of care and daily life. The policy documented residents would receive care in a manner that enhances and maintains their dignity and respect.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents with one resident reviewed for discharge. Based on observation, interview, and record review, the facility failed to provide a written discharge summary or recapitulation of the stay for Resident (R) 37. This placed the resident at risk for impaired rights related to continuity of care. Findings included:- R37's Electronic Health Record (EHR) documented diagnoses that included chronic pain and hypothyroidism (a condition characterized by decreased activity of the thyroid gland).R37's Nursing Home Discharge Minimum Data Set (MDS), dated [DATE], documented R37's discharge from the facility to the community on 06/19/25.R37's EHR noted Physician Orders, which documented an order to discharge to independent apartments on Thursday, 06/19/25, dated 06/17/25.The EHR Progress Notes documented:On 06/11/25 at 11:09 AM, fax communication with the physician who requested orders to discharge the resident to home.On 06/12/25 at 10:25 AM, fax communication received from the physician with written orders to discharge the resident to home on or about 06/19/25 with medications and treatments.On 06/17/25 at 10:33 AM, the physician performed a routine 60-day visit with R37 and documented an order to discharge to independent apartments on 06/19/25.On 06/19/25 at 10:44 AM, staff documented R37's family was at the facility moving R37's belongings to an independent apartment due to R37 being discharged the same day.On 06/19/25 at 12:27 PM, staff documented a discharge meeting was held for R37. Administrative Nurse D reviewed the medication list with R37, and R37 had made arrangements for follow-up appointments with her primary healthcare provider as well as transportation arrangements with family in the community.On 06/19/25 at 01:26 PM, staff documented R37 was at the nurses' station at 01:00 PM and told staff she was leaving. Staff documented R37 was supplied with her medications.On 06/19/25 at 01:31 PM, staff documented fax communication with the physician to inform them R37 was discharged to home at 01:00 PM.R37's EHR lacked evidence that the facility provided a written discharge summary or recapitulation of the stay to R37 or R37's family.On 08/20/25, the facility provided a printed copy of R37's Planned Discharge - Interdisciplinary evaluation that documented a discharge date , brief reason for admission, treatment provided, treatment progression, and reason for discharge. The evaluation did not contain the condition at the time of admission, destination of discharge, to whom the resident was released, disposition of medications and/or personal possessions, instructions for after care/continuity of care, or summary of the stay.During an interview on 08/20/25 at 01:31 PM, Administrative Nurse D revealed the discharge summary and recapitulation should be in the EHR under the Evaluations tab. Administrative Nurse D confirmed that R37's EHR Evaluations tab lacked a recapitulation of the stay, and a brief recapitulation was documented on a Planned Discharge - Interdisciplinary evaluation. During an interview on 08/20/25 at 01:36 PM, Administrative Staff A stated the recapitulation should be in each resident's medical record.During an interview on 08/20/25 at 04:30 PM, R37 stated during the actual discharge process on 06/19/25, she was provided with a reconciliation of her medications and was not provided with a written discharge summary or recapitulation of the stay. R37 stated the facility did not assist her with coordinating transportation in the community or follow-up appointments with her primary care provider because she had already made those arrangements independently.The facility's Resident Rights policy, dated 01/10/25, did not address the discharge process.The facility's Admission, Transfer, and Discharge Policy policy, dated 01/10/25, documented the facility would comply with regulations to protect residents' rights during discharge. At least 30 days advanced written notice would be provided, except in case of emergency situations, and would include reason, effective date, location, contact information for LTCO (Long Term Care Ombudsman) and SA (State Agency), and appeal rights. The policy did not document providing a written discharge summary, recapitulation of stay, or reconciliation of medications to the resident or residents' representatives.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for five residents: Resident (R) 7, and R4 related to personal alarms; R5 related to pressure ulcers and medications; R2 related to dental; and R25 related to nutrition. This deficient practice placed the affected residents at risk for impaired care due to unidentified care needs. Findings included:During an observation and interview on 08/19/25 at 01:23 PM, R7 reported she has had some falls and hit her head, which she needed staples sometime this past year. Observation revealed a bed and chair alarm in her room.R7's Care Plan in the Electronic Health Record (EHR) directed staff to provide a silent alarm on R7's bed and chair dated 09/11/24. R7's EHR recorded a Quarterly MDS, dated [DATE], and an Annual MDS, dated [DATE], which both lacked documentation of R7's bed and chair alarm in Section P.During an observation and interview on 08/19/25 at 01:39 PM, R4 sat in a recliner with her representative present. R4's representative pointed out the silent alarm under R4 and stated the alarm was utilized while R4 was in bed or in the recliner. R4's EHR recorded a Care Plan that noted staff provided a silent alarm on the bed and chair dated 04/20/25. R4's EHR recorded a Significant Change MDS, dated [DATE], which lacked documentation of R4's bed alarm in Section P.During an interview on 08/20/25 at 05:25 PM, Certified Nurse Aide (CNA) T reported that R4 and R7 had a silent alarm on their bed and chair, and have had them for quite some time.During an interview on 08/21/25 at 12:00 PM, Administrative Nurse E confirmed both R4 and R7's comprehensive and quarterly assessments were coded incorrectly for alarms.R5's Electronic Health Record (EHR) recorded a Physician Order for Remeron (an antidepressant used to treat mood disorders) 30 milligram (mg) tablet dated 11/24/21. R5's Quarterly MDS, dated [DATE], lacked documentation of R5's antidepressant in Section N.R5's EHR recorded a Skin/Wound Note dated 12/30/24, which documented a wound to the coccyx had healed.R5's EHR recorded a Skin/Wound Note dated 01/06/25, 01/13/25, 01/20/25, 01/27/25, documented no skin issues noted.A Progress Note dated 02/01/25 at 02:36 PM documented the resident transferred to the hospital.The admission Skin Note dated 02/04/25 at 03:08 PM, documented a Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) on the coccyx (area over the tailbone); the wound was healed prior to leaving the facility but present on readmission. R5's Quarterly MDS, dated [DATE], incorrectly recorded the resident had one facility-acquired Stage 3 (full-thickness pressure injury extending through the skin into the tissue below).During an observation on 08/21/25 at 8:50 AM, R5 had a dressing noted on her coccyx during care.During an interview on 08/21/25 at 12:55 PM, Administrative Nurse D confirmed that R5's pressure ulcer was healed in December of 2024, and when R5 was readmitted from the hospital in February 2025, the wound was open.During an interview on 08/21/25 at 01:20 PM, Administrative Nurse E confirmed R5's quarterly assessment dated [DATE] was coded incorrectly for antidepressant and facility-acquired pressure ulcer.- R2's Electronic Health record (EHR) recorded a Progress Note 03/04/25 at 11:10 AM, which documented R2's upper dentures and lower dentures were broken.R2's EHR recorded an admission Assessment dated 03/04/25 at 12:33 PM, which documented R2 had upper dentures.R2's Care Plan, revised 03/10/25, documented the resident had upper dentures and directed staff to provide a toothbrush and soak the dental device at night. The plan instructed staff to report changes, problems with gums, dental devices, or signs of pain such as grimacing while eating. The plan noted R2's lower dentures were lost prior to admission.R2's EHR recorded an admission MDS, dated 03/10/25, which lacked documentation in Section L of R2's edentulous (no natural teeth) status.During an interview on 08/19/25 at 9:16 AM, R2 reported she had been without a lower denture for six months; she reported she lost them at dinner at a restaurant.During an interview on 08/21/25 at 01:20 PM, Administrative Nurse E confirmed the admission assessment was coded incorrectly for R2's dental status.R25's Electronic Health record (EHR) recorded a Physician Order for a regular portion-regular diet with soft texture; ground meat or cut up in small pieces; always serve with gravy or sauces, dated 12/25/24.R25's Care Plan, revised 12/25/24, instructed staff to offer the resident a regular diet with regular portions, soft texture (meat cut up in small pieces or ground meat texture with gravy or sauce).R25's Annual MDS, dated [DATE], and Quarterly MDS, dated 08/05/25, lacked documentation in Section K of R25's mechanically altered diet (require change in texture of food or liquids).During an observation on 08/19/25 at 01:54 PM, R25 sat in his recliner, drooling from his mouth. R25 wiped off his face and gurgled when he talked.During an interview on 08/21/25 at 01:20

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 33 residents, and one main kitchen. Based on observation, record review and interview the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food borne bacteria. This placed the residents at risk for food borne illnesses.Findings included:- Observation of the kitchen and food storage areas on 08/19/25 at 07:40 AM revealed the following areas of concern:Dry storage concerns:Four cases of soda cans and a 50-pound bag of sealed flour were stored on the floor.One unsealed bag of marshmallows.One bag of unsealed russet instant mashed potatoes.A large container of pinto beans that was not sealed with the lid all the way.Several bottles of spices with no date opened and no expiration date.Walk-In Cooler concerns:Several containers of caffeine and sunshine drink with straws in them, with initials TP and no date. Two bags of fresh broccoli unsealed,One bag of sliced onions unsealed. One box of Pizza [NAME] pizza, no date, no name.One unsealed bag of shredded cheese,One bowl of mixed fruit labeled Joyce, no date.Walk-in freezer concerns:One bag of unsealed biscuits, an unsealed waffle, and a bag of unsealed ground beef.A plastic storage container on the top shelf, no date, no label, looks like ice and noodles.Two free-standing refrigerators in the kitchen had one bag of unsealed roast beef and an open gallon of milk with no date when opened.During the second observation on 08/20/25 at 10:20 AM, revealed several cooking pans with black colored debris on the bottom of them; one frying pan was dented, and four cutting boards had several scratches noted over the surfaces. During an interview on 08/20/25 at 07:55 AM, Certified Dietary Manager (CDM) BB reported that some of the items in the fridge and freezer were staff food items and that they have stored those items in the fridge for over 30 years, and no one had ever had a concern with staff items in the fridge. CDM BB reported that the flour and soda pop should not have been placed on the floor and verified that it was delivered on 08/13/25. CDM BB said staff were expected to keep items off the floor. Additionally, CDM BB stated staff were expected to label all food items in the kitchen when opened, and all items should be properly sealed.During an interview on 08/20/25 at 10:30 AM, CDM BB reported she would have the pans and cutting boards replaced.During an interview on 08/20/25 at 01:00 PM, Administrative Staff A stated she expected all food items to be stored, sealed, labeled, and dated properly. Additionally, Administrative Staff A said she expected kitchen equipment to be in good working order.The facility's policy Food Receiving and Storage dated 10/2017 documented personal staff items and food storage.Employees may store their personal items in employee refrigerators or designated storage areas that follow sanitation and appropriate storage. Employee personal staff items may be stored in designated areas, including food storage areas, provided they are properly covered, clearly labeled with the staff member's name, and maintained in a sanitary manner.The facility's policy Dietary Food Storage dated 01/10/25 documented food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. All food items taken out of original packaging will be labeled and stored in air-tight containers. The label must include the received by date and/or open date.The facility's policy Food Handling & Preparation dated 01/10/25 documented to maintain clean, organized kitchens and equipment.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. The facility reported a census of 33 residents. Based on observations, interviews and record review, the facility failed to maintain and/or dispose of kitchen garbage and refuse properly. This placed facility residents at risk for insect or rodent infestation.Findings included:- During a tour of the kitchen on 08/19/25 at 07:40 AM, observation revealed three garbage cans with no lids on them. During an observation on 08/20/25 at 10:20 AM, the same three garbage cans were found with no lids in the kitchen. Certified Dietary Manager (CDM) BB reported that the garbage cans did have lids and pulled a lid out from behind a garbage can and placed it on the can next to the steamer counter. CDM BB reported that the garbage cans should be covered. During an observation on 08/20/25 at 11:25 AM, the garbage can that was approximately three feet away from the stove had no lid. Dietary Staff CC had just finished cooking hamburgers and reported that the garbage cans in the kitchen rarely had a lid placed on them. During an interview on 08/20/25 at 01:00 PM, Administrative Staff A reported she expected all the garbage cans to always have the proper lids on them in the kitchen. The facility's policy Waste Disposal, revised on 10/10/24, states that all garbage will be disposed of daily and as needed throughout the day. Trash will be deposited into a sealed container outside the premises.The facility did not provide a policy on waste management.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility reported a census of 33 residents. Based on interview and record review, the facility failed to submit complete and accurate staffing information to the Payroll-Based Journaling (PBJ) as required. Findings included:- Review of the PBJ Staffing Data Report for Fiscal Year (FY) 2024 Quarter (Q) 3 (April 1 - June 30) and FY 2024 Q4 (July 1 - September 30) revealed the facility did not have Licensed Nursing Coverage 24 hours a day on the following dates: 04/13/24, 04/28/24, 05/04/24, 05/05/24, 05/10/24, 05/11/24, 05/12/24, 05/25/24, 07/03/24, 07/07/24, 08/18/24, 09/22/24. Review of the facility's nursing schedule and payroll data for the above dates revealed the facility had 24-hour nursing coverage. During an interview on 08/20/25 at 04:00 PM, Consultant HH provided the nursing schedule and payroll data that revealed the time-keeping system had automatically removed a 30-minute lunch period for the above dates, even though the nurses remained in the building. The facility did not provide a policy related to PBJ reporting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported a census of 33 residents. The sample included 12 residents. Based on interviews, observation and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing direct care to a Resident (R) 5 with a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure injury. The facility further failed to ensure adequate hand hygiene during personal care for R5 and R32 when staff failed to complete adequate hand hygiene. The facility failed to deliver food in a sanitary manner for several residents in the dining room. These deficient practices had the potential to spread infections to the residents in the facility.Findings included:- Observation on 08/20/25 at 05:49 PM, Certified Medication Aide (CMA) R delivered food to the resident's tables with thumbs touching the eating surface of the plate.Observation on 08/20/25 at 05:49 PM, Certified Nurse Aide (CNA) P delivered food to residents with thumbs touching the eating surface of the plates.Observation on 08/20/25 at 05:55 PM, CNA O delivered food to residents with thumbs touching the eating surface of the plates.Observation on 08/20/25 at 06:09 PM, CNA Q delivered plates of food to the residents with thumbs touching the eating surface of the plates.Observation on 08/21/25 at 08:50 AM, CNA S and CNA M provided peri-care care to R5. R5 had EBP signage and personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) located outside her room. Neither CNA donned a gown, but only wore gloves. CNA S removed her glove from her right hand in between the dirty and clean actions during peri-care provided and applied a new glove to her right hand without performing hand hygiene. CNA S and CNA M completed peri-care to R5, then removed their gloves. Both CNA applied a clean pair of gloves without performing hand hygiene first and proceeded to assist R32, R5's roommate, with peri-care. CNA S and CNA M transferred R32 back to her recliner from the shared bathroom. CNA S and CNA M then removed their gloves but did not perform hand hygiene. They exited the room. CNA M pushed the mechanical lift out of the room and down the hall. CNA M stopped at R1's room as the resident asked the CNA M to do a couple of things in her room. CNA M entered R1's room without performing hand hygiene, adjusted the thermometer, and moved some items in the room; then CNA M came out of the room and, without performing hand hygiene, continued to push the mechanical lift down the hall to the storage room. CNA M pushed the lift into the room and then performed hand hygiene. The mechanical lift was not cleaned off after use and before being placed in the common storage area.During an interview on 08/20/25 at 06:00 PM, Consultant Staff GG said he expected staff to keep their hands clear of the eating surface of plates since that was an infection control concern. He stated staff were provided education.During an interview on 08/21/25 at 09:10 AM, CNA S and CNA M reported they should have worn a gown when providing care to R5, and reported they normally washed their hands after care was provided. CNA M reported she normally wiped down the mechanical lift after each use.During an interview on 08/21/25 at 10:18 AM, Licensed Nurse (LN) G reported the staff should perform hand hygiene after removing gloves and between resident care provided. LN G said the mechanical lift should be sanitized after use, and confirmed the staff were required to wear gowns and gloves with EBP residents during the hands-on care.During an interview on 08/21/25 at 01:06 PM, Administrative Nurse D stated she expected staff to wear the required PPE for residents who have EBP. She stated she expected staff to complete hand hygiene when gloves were removed and between resident care. She said she expected staff to sanitize the shared equipment between residents.The facility's policy Infection Control dated 01/10/25, documented staff perform hand hygiene before and after direct contact with a resident and immediately after removing gloves.The facility's policy Enhanced Barrier Precautions dated 11/12/24, documented EBP were implemented as one intervention this facility uses to reduce transmission of resistant organisms that employs targeted PPE use during high contact resident care activities. The facility's policy Food Handling & Preparation dated 01/10/25, documented ensuring safe, nutritious, and palatable food service in compliance with federal and state requirements. Use tongs, scoops, or utensils-not bare hands-to prepare and serve food.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. The facility reported a census of 33 residents. Based on interview and record review the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program (IPCP). This failure has the potential to affect all 33 residents.Findings included:- During an interview on 08/19/25 at 07:50 AM, Administrative Staff A revealed she was the facility IP, and Administrative Nurse D assisted with the task. Administrative Staff A provided a certificate for completion of Nursing Home Infection Prevention Training Course dated 01/22/25.During an interview on 08/21/25 at 01:06 PM, Administrative Staff A reported she had a bachelor's degree in Aging Sociology but no health-related degrees. She confirmed she was the IP of the facility while Administrative Nurse D was taking the IP class to receive her certification. During an interview on 08/21/25 at 01:10 PM, Consultant Staff GG stated he thought any staff member could be the IP of the facility.The facility's Infection Control Policy dated 01/10/2025, documented the IP was responsible for overseeing the infection control program, including but not limited to surveillance of infections, tracking and trending infections in the facility, and having primary training in nursing, medical technology, microbiology, epidemiology, or another related field.