STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Mental Health	500 Peabody Peabody, KS 66866

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. The facility identified a census of 42 residents. The sample included 12 residents, with one reviewed for behavioral services. Based on observation, record review, and interviews, the facility failed to provide adequate behavioral health services, including resident-centered interventions to address Resident (R)15's auditory hallucinations related to his schizophrenia and bipolar disorder. On 09/23/35, R15 had exit-seeking behaviors as he heard voices telling him he was supposed to discharge from the facility. The facility staff did not report the incident, and the facility did not assess and identify possible triggers or implement interventions to address the auditory hallucinations. R15's mental provider assessed the resident on 10/07/25 but did not address this resident's recent auditory hallucinations or the associated behaviors. On 11/02/25, R15 again had auditory hallucinations telling him to go outside, so R15 entered the door code and exited the facility without staff knowledge or supervision. R15 was outside alone for 1.5 hours, and was located two blocks from the facility, walking towards the highway in 39-degree Fahrenheit temperatures. Rl5's behavioral manifestations were not assessed by the mental health provider until 11/05/25. The failure to identify and implement behavioral health interventions placed R15 in immediate jeopardy.Findings included: - The Medical Diagnosis section within R15's Electronic Medical Records (EMR) included diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) with bipolar type (a major mental illness that causes people to have episodes of severe high and low moods). R15's 02/15/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R15 hallucinated (sensing things while awake that appear to be real, but the mind created) and had delusions (untrue, persistent belief or perception held by a person although evidence shows it was untrue), but no other behaviors. The MDS documented R15 required setup assistance with dressing, hygiene, and bathing, and was independent with other activities of daily living (ADL). The MDS documented R15 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. R15's Psychotropic Drug Use Care Area Assessment (CAA) completed 02/07/25 indicated he used psychotropic medications. R15's CAA did not trigger for mood or behaviors. R15's 12/01/25 Quarterly MDS documented a BIMS score of 14. The MDS documented R15 did not hallucinate or have delusions, but did have other behaviors. R15 had behaviors directed toward others for one to three days during the lookback period. R15 wandered on four to six days during the lookback period. The MDS documented R15 required setup assistance with dressing, hygiene, and bathing, and was independent with other ADL. The MDS documented he received antipsychotic and antianxiety medication (a class of medications that calm and relax people). R15's Care Plan, revised on 08/17/23, documented he had a psychosocial well-being problem related to lack of motivation and distractions from auditory hallucinations. The intervention initiated on 12/08/20 and revised on 03/25/21 directed staff to allow R15 time to answer questions and verbalize his feelings, encourage participation with decisions though the resident depends on other people to make decisions, and encourage the resident to set realistic goals. An intervention dated 07/07/23 documented the resident needed to identify the (continued on next page)

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

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	causative and contributing factors to clarify what the voices told him, such as his family did not die in a plane crash. R15's Care Plan, revised on 11/19/24, documented he used psychotropic medications related to behavior management for a diagnosis of schizoaffective bipolar type. The plan noted on 10/21/24, Abilify (an antipsychotic medication) was added for hallucinations and delusions. Staff monitored behaviors. R15's Care Plan recorded a focus, initiated on 11/27/20 and revised on 11/07/25, that noted R15 had an elopement risk score of eight and had a history of attempts to leave the facility unattended. The focus noted R15 left the facility unattended on 11/02/25 and made an additional attempt on 11/04/25. An intervention dated 11/02/25 and revised on 11/07/25 recorded R15 eloped from the facility. He was looking for someone to take him to church, and voices told him he needed to go to church that day. The resident was screened by a psychiatric provider for potential admission to a state hospital. R15's Care Plan listed a focus, initiated on 10/05/24 and resolved on 09/03/25, which indicated the resident had a behavior problem and sprayed his roommate with a fire extinguisher due to being commanded to do so by voices. The Alert Note on 09/07/25 at 05:45 PM documented the nurse received a report that R15 was observed at the back door by the laundry area early in the morning before the nurse arrived. The note documented R15 made no attempts or said anything about leaving the rest of the day. The Behavior Note on 09/23/25 at 03:16 PM recorded R15 reported he received messages telepathically that he was leaving that day and was trying to go out the front door. The nurse advised R15 the voices were confused and assured him he was not leaving that day. R15 tried to leave twice and then went to the room. R15 frequently complained of communicating with others telepathically. R15's Psychiatric Visit note dated 10/07/25 by Consultant GG documented the reason for the visit was psychiatric medication review. The provider started R15 on a new medication for abnormal movements related to the antipsychotic medications he received. The note lacked mention of the incident on 09/23/25 or auditory hallucinations. The Behavior Note dated 11/02/25 at 09:49 AM documented staff were looking for R15 and located him walking out of the tree line down the road from the facility. Upon return to the facility R15 stated he was not hurt, just cold. R15 told staff he had been looking for someone so they could go to church. The Behavior Note on 11/02/25 at 10:37 AM documented another resident notified the nurse at 07:45 AM that R15 was out of the facility. The nurse immediately sent a staff member to look for R15 and followed the procedure until R15 was located. The Health Status Note on 11/02/25 at 02:17 PM documented R15 arrived back at the facility at 09:59 AM with the Director of Nursing. He reported he was cold and not injured. The Health Status Note on 11/02/25 at 03:29 PM documented at approximately 01:00 PM R15 was screened by a mental health assessment company and was awaiting a response. The Alert Note on 11/02/25 at 03:31 PM documented the nurse received a call from the mental health screening company, and they were not admitting R15 to another facility for psychiatric needs. The Health Status Note dated 11/02/25 at 02:17 PM noted R15 returned to the facility with Administrative Nurse D at approximately 09:50 AM. Staff assessed R15's vital signs and his temperature registered as low and would not read at first. Staff wrapped R15 in a blanket, upon recheck his temperature was 96 degrees Fahrenheit (normal temperature is 97.8 degrees F. R15's pulse was 110 beats per minute (normal pulse is 60-100 beats per minute). R15 had a small scratch to forearm. R15 reported he was still cold and declined breakfast but said he would get a snack. R15's EMR lacked any behavioral intervention related to voices telling him to elope after the 09/23/25 and 11/02/25 incidents until 11/05/25. The Psych Visit note on 11/05/25 at 05:39 PM revealed the psychiatric provider, Consultant GG, saw R15 for follow-up psychiatric medication evaluation. R15 exhibited an increase in delusional thinking and believed he was telecommunicating with others. He believed he was being discharged and was exit seeking, going to the front door and pushing on the keypad. Consultant GG requested a screen for an inpatient hospitalization and ordered to increase the resident's Abilify to 20 mg daily. On 12/08/25 at 10:12 AM, R15 lay in bed with the covers over him. He appeared clean, but his hair was disheveled. He agreed to answer questions. R15 responded to every question first with a whisper of Yes, No, or It's okay, go ahead and tell her. He reported he left the facility because he was going across the street to (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	his house. R15 reported he bought the house telepathically about a year ago. R15 stated he put in the door code and left. When asked what the code was, he said, 756, 757, 758, 759. When asked how he got the code, R15 responded with, I guess the Holy Spirit gave it to me. On 12/10/25 at 11:23 AM, R15 lay in bed. R15 answered questions without whispering before responding. R15 stated the voices come and go, and that day, the voices were not there. He reported he does not want to go to activities because he is afraid of a psychotic episode where the voices flood his head with negative voices. A review of the area where R15 was hiding revealed a line of trees with barbed wire present. The area was approximately 1300 feet from a highway with varying posted speeds of at least 55 miles per hour. According to Wunderground.com, the temperature on 11/02/25 at 07:56 AM was 39 degrees F. The temperature was 44 degrees F. at 08:56 AM and 48 degrees F. at 09:56 AM. During an interview on 12/10/25 at 11:01 AM, Certified Nurse Aide (CNA) O stated staff did elopement training for R15, and they do behavior training all the time. CNA O reported R15 does not have any behaviors, but R15 did have voices that tell him he is going to another place. CNA O said when R15 did that, staff reminded him the facility was working on discharge plans, and the Director of Nursing (DON) would let him know when he was ready for discharge. CNA O stated R15 was very redirectable and returned to his room. She said if any resident had a behavior, staff reported it to the DON. During an interview on 12/09/25 at 02:28 PM, Licensed Nurse (LN) G stated R15 was hiding in the bushes down the street from the facility while staff searched for him. She said R15 frequently approached the nurse's station saying he was there for his discharge, but he could be easily redirected. During an interview on 12/10/25 at 11:17 AM, LN H stated the staff received ongoing behavior training and received extra elopement training following R15's elopement. She said R15 did not go to the door when she worked, but did ask her if he had been discharged and if he was leaving that day. She told him no, and he went back to his room. LN H stated R15 did hear voices, sometimes the voices were more than other times. LN H said R15 was easily redirected, and if there was a change in a resident's behavior, LN H would immediately tell the DON, then the owner/psychiatric provider (Consultant GG). During an interview on 12/09/25 at 02:31 PM, Administrative Nurse D stated R15 was not actually physically trying to get out on 09/23/25; he was telepathically communicating with someone, then said he was going to leave and went to stand by the door; he did not try to leave. Administrative Nurse D stated R15 did that sometimes and would say he was discharging that day. Administrative Nurse D said staff told R15 no, and he went back to his room and did not try to get out. Administrative Nurse D stated she did not tell any other staff because it was not a change, and R15 did not actually attempt to get out. On 12/09/25 at 05:38 PM, Consultant GG stated she saw residents quarterly and as needed. Consultant GG confirmed the last visit with R15, before the 11/02/25 incident, was on 10/07/25 and verified the visit did not address the auditory hallucinations, stating it was not a new issue. On 12/10/25 at 11:43 AM, Consultant GG stated she was aware of the events of 09/23/25, but did not address it because it was not a change, and R15 did not attempt to get out. R15 was redirected when he was by the door, and his baseline included delusions. On 12/10/25 at 12:04 PM, Administrative Staff A reported R15 received a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) and frequent checks after the 11/02/25 incident. The facility changed the door codes immediately, and all staff were called in to receive training. The facility's Behavioral Health Services policy dated 02/03/25, documented each resident will receive and the facility will provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. On 12/10/25 at 06:10 PM, Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed of the IJ. The facility identified, implemented, and completed corrective measures on 11/05/25, which included the following:1. R15 received increased monitoring and a WanderGuard to address the wandering and exit-seeking behavior.2. Consultant HH assessed the resident's changes in behaviors and implemented changes to the plan of care to address the auditory hallucinations on 11/05/25.3. An emergency QAPI meeting was held to review interventions. The onsite surveyor verified the above completed corrective action. Due to all (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	corrections completed prior to the onsite survey, the deficient practice was cited as past noncompliance at a scope and severity of J (isolated, immediate jeopardy).

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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 42 residents. Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for nine residents, Resident (R) 33, R2, R31, R49, R17, R42, R10, R15, and R16, related to uncomfortable, torn, and/or damaged mattresses with exposed filling on nine mattresses rendering them unsanitizable. Findings included:- Observations on 12/10/2025 at 09:00 AM, during an environmental tour with Maintenance Staff V and Maintenance Staff W, revealed the following concerns for nine residentsR33's mattress was worn.R2's mattress had a tear at the bottom.R31's mattress had multiple tears on the bottom side.R49's mattress had multiple tears on both the bottom and top.R17's mattress had tears along the side, exposing the bed cover, which was worn and ripped.R42's mattress had a tear along the side. R10's mattress had multiple tears/rip areas in the cover at the top of the bed.R15's mattress had multiple tears/rips on the side.R16's mattress had multiple tears.All nine mattresses with visible tears had unsanitizable surfaces noted. On 12/10/2025 at 09:00 AM, R33 reported his mattress was uncomfortable. On 12/10/2025 at 10:33 AM, Housekeeping Staff U reported she would notify nursing staff and/or Consultant Staff HH of mattresses in disrepair, which would need to be replaced in order to provide a sanitizable, comfortable sleep surface for the residents. On 12/10/2025 at 10:35 AM, Certified Medication Aide (CMA) R reported the facility's maintenance room had a sign on the door directing staff to report environmental concerns. On 12/10/2025 at 10:37 AM, Consultant Staff HH, Maintenance V, and Maintenance W verified the above findings and the need to replace the mattresses to ensure a comfortable and sanitizable sleep surface for the residents. Consultant Staff HH reported the staff should report damaged mattresses to the maintenance staff or the administrator. She reported she was not made aware of the need to replace mattresses. The undated facility policy titled Westview [NAME] General Cleaning and Maintenance of Resident Environment documentation included that Management staff and Environmental Service staff will establish and maintain a safe and functional environment. Environmental Service and Custodial staff will keep furnishings and equipment safe and in good repair.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 42 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 three residents: Resident (R) 5, related to restraint; R1 related to catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid); and R2 related to dental. Findings included:1. R5's Electronic Medical Record (EMR) recorded a Annual Minimum Data Set (MDS) dated [DATE] that documented R5 had a bed rail used daily under the physical restraints (are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) section. During an observation and interview on 12/08/2025 at 09:04 AM. R5 ambulated in the hallway near his room. He opened the door to his room to complete an interview. Further observation of the room revealed a half side-rail secured to the right side of R5's bed. R5 reported he used the side rail to transfer in and out of his bed. During an interview on 12/10/2025 at 07:00 AM, Certified Medication Aide (CMA) R reported that R5 used the side-rail on his bed to help him be independent with his transfers. During an interview on 12/10/2025 at 10:40 AM, Administrative Nurse D reported that she had been instructed to code any bed rail as a restraint on the MDS. Administrative Nurse D reported that R5 used the bed positioning rail to assist him in being more independent with transfers and bed mobility, and reported that the bed positioning rail was not a restraint for R5. 2. R1's EMR recorded an Annual MDS dated [DATE], which recorded R5 was always continent of urine. R1's Care Plan dated 04/22/2025 documented staff instructed to provide R1 reminders to allow staff to assist him in emptying his leg bag. R1's EMR recorded a Physician Order that directed to empty the leg bag four times a day, and as needed every two hours related to neuropathic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), dated 11/21/2023. During an observation and interview on 12/08/2025 at 09:25 AM, R1's catheter leg bag was full of urine. R1 stated he would alert staff for assistance. During an interview on 12/10/2025 at 10:40 AM, Administrative Nurse D reported she coded the MDS inaccurately, and the correct code she should have documented was Not Rated. 3. R2's EMR recorded an admission MDS dated [DATE], which recorded R2 had no dental issues in the dental section R2's EMR recorded an Admit Screener dated 01/11/2025, which recorded R2 had broken or carious (tooth decay or cavities) teeth. During an observation and interview on 12/08/2025 at 10:11 AM, R2 reported he had asked to see a dentist and was told insurance would not pay for a partial denture. R2 opened his mouth, and observation revealed missing and broken teeth on the bottom gumline. During an interview on 12/09/2025 at 03:45 PM, Licensed Nurse (LN) G reported that R2 had teeth missing and cavities. LN D reported that R2 had recently completed an antibiotic for tooth pain and infection. LN G reported R2 had a pending dental appointment. During an interview on 12/10/2025 at 10:40 AM, Administrative Nurse D reported that the MDS was coded inaccurately and reported that the dental issues were not captured. Administrative Nurse D reported she expected the MDS to be documented accurately. The facility's undated policy Westview Manor of [NAME] Minimum Data Set Accuracy Audits documented the facility was committed to ensuring the accuracy, timeliness, and completeness of all MDS assessments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 42 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for Resident (R) 2's left shoulder limited mobility and shoulder pain and R47s oxygen, refusal of cares, and continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) use. Findings included:1.R2's Electronic Medical Record (EMR) revealed diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) and chronic pain. R2's 10/27/25 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R2's MDS recorded that he had impairment of the upper extremity on one side. R2's was independent for dressing and mobility. R2's 01/24/25 admission MDS documented a BIMS of 15. R2's MDS recorded he had no impairment of his upper extremities. R2 was independent for dressing and mobility. R2's 01/24/25 Activities of daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) documented he was a new admission and was monitored for the ability to complete tasks. R2 would maintain his current level of functioning. R2's Care Plan lacked documentation for left shoulder pain and therapy. R2's Physician's Orders documented Physical and Occupational therapy evaluation dated 10/22/25.R2's Physician's Orders documented meloxicam (a prescription nonsteroidal anti-inflammatory drug used primarily to relieve pain) 7.5 milligrams (mg), by mouth twice a day for pain dated 10/29/25. R2's Physician Visit Note on 10/22/25 documented R2 reported shoulder pain without any history of injury or trauma. The pain was described as mild on one side and more pronounced on the other, particularly with certain movements such as pushing against resistance. R2 denied running into anything or sustaining any injuries. The note documented a new order for physical therapy, and if no improvement, refer to orthopedics for further evaluation and possible magnetic resonance imaging (MRI-medical imaging used to view soft tissue). R2's Progress Note on 10/29/25 at 02:02 PM documented R2 was out of the facility at the local hospital for left shoulder pain evaluation. R2's Hospital Note on 10/29/25 at 03:58 PM documented left shoulder pain follow-up with an orthopedic consult and a new order for meloxicam 7.5 mg by mouth twice a day. R2's Progress Note on 11/03/25 at 05:27 PM documented he had an appointment with orthopedics on 11/20/25 at 07:30 AM for treatment of the left shoulder. R2's Progress Note on 11/20/25 at 09:05 AM documented R2 returned from the orthopedic consult with orders for physical therapy two to three times per week for left shoulder pain, and he needed an MRI of the painful area. R2's Progress Note on 12/03/25 at 12:42 PM documented an MRI without contrast was scheduled at the hospital on [DATE] at 02:45 PM. During an observation on 12/09/25 at 12:40 PM, R2 sat in the dining room and ate lunch with no obvious issues. During an interview on 12/08/25 at 10:13 AM, R2 reported he had been waiting for therapy because he had limited motion in his left shoulder and a rotator cuff tear, which caused pain. R2 reported that the pain medication he received worked for the pain. During an interview on 12/09/25 at 09:20 AM, Certified Medication Aide (CMA) R reported R2 recently started to complain of left shoulder pain and R2 received medications for the pain. During an interview on 12/09/25 at 03:45 PM, Licensed Nurse (LN) G reported that R2 was scheduled for an MRI this month. LN G said Administrative Nurse D completed the care plans. During an interview on 12/10/25 at 10:30 AM, Administrative Nurse D confirmed R2's Care Plan lacked documentation and interventions for his left shoulder pain and reported she expected the care plan to be current with residents' concerns, goals, and interventions. 2. R47 's EMR revealed diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and sleep apnea (a disorder of sleep characterized by (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	periods without respirations). R47's 10/01/25 admission Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R47 rejected evaluation or care daily. The MDS documented R47 required oxygen and a non-invasive mechanical ventilator, such as a continuous positive airway pressure (CPAP). R47's 10/06/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R47 rejected care frequently, which was in part due to hypoxia (inadequate supply of oxygen) due to low oxygen saturation (percentage of oxygen in the blood) below 80 percent. R47 used a CPAP due to sleep apnea and had increased hypoxia at night, which could increase confusion. R47 would be confused with low oxygen saturation and was resistant to wearing oxygen. R47's 10/15/25 Care Plan lacked documentation regarding oxygen and CPAP use. R47's Physician Orders ordered to obtain oxygen saturation twice a day, date ordered 09/18/25. R47's Physician Orders ordered continuous oxygen 3 to 4 liters; oxygen saturation must stay above 80 percent, date ordered 09/24/25. R47's Progress Note dated 09/18/2025 05:12 PM documented R47 arrived via ambulance. R47 was alert and oriented. R47 required a wheelchair, walker, oxygen, and CPAP. R47's Progress Note dated 09/24/2025 at 05:20 AM documented R47 agreed to try his CPAP machine this evening at bedtime around 10:00 pm. R47's Progress Note dated 10/13/25 at 05:22 AM documented R47's eyes were closed. Staff educated R47 that they were going to readminister his oxygen as his oxygen saturation was 52 percent on room air. Staff applied oxygen at 3 liters, and R47's oxygen saturation increased to 84 percent. His lower extremities were warm to the touch, but his bilateral legs were dark purple. During an interview on 12/11/25 at 09:44 AM, Licensed Nurse H reported that Administrative Nurse D completed all the care plans. During an interview on 12/11/2025 at 11:05 AM, Administrative Nurse D reported that she realized R47's Care Plan was not completed by the MDS nurse, who no longer worked at the facility, as she had not completed her assigned work, which included care plans. Administrative Nurse D stated she expected the care plan to be completed in a timely manner and include person-centered care goals and interventions. The facility's policy Care Plan Revisions undated documented the care planning process, which included resident assessment, goal setting, intervention, referrals to other health care professionals, evaluation of resident responses to treatment, and revision of care and treatment in order to meet the resident's needs. Changes in a resident's condition always require changes to be made in the plan of care, either by a change in individual approaches or by the addition of new problems to the plan of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 42 residents. The sample included 12 residents. Based on interview and record review, the facility failed to provide services to meet professional standards of care when staff failed to ensure Resident (R) 47's Electronic Medical Record (EMR) contained appropriate documentation to include physician notifications and R47's refusals to be transferred to the local hospital. Findings included:- R47 's EMR revealed diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and sleep apnea (a disorder of sleep characterized by periods without respirations). R47's [DATE] admission Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R47 rejected evaluation or care daily. The MDS documented R47 required oxygen and a non-invasive mechanical ventilator, such as a continuous positive airway pressure (CPAP- a ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). R47's [DATE] Cognitive Loss/Dementia Care Area Assessment (CAA) documented R47 rejected care frequently, which was in part due to hypoxia (inadequate supply of oxygen) due to low oxygen saturation (percentage of oxygen in the blood) below 80 percent. R47 used a CPAP due to sleep apnea and had increased hypoxia at night, which could increase confusion. R47 would be confused with low oxygen saturation and was resistant to wearing oxygen. R47's [DATE] Care Plan lacked documentation regarding oxygen and CPAP use. Furthermore, the care plan lacked R47's behaviors of refusal of care. R47's Physician Orders ordered to obtain oxygen saturation twice a day, ordered [DATE]. R47's Physician Orders ordered continuous oxygen 3 to 4 liters; oxygen saturation must stay above 80 percent, ordered [DATE]. R47's Medication Administration Record (MAR), reviewed from [DATE] through [DATE], lacked an area for documentation of continuous oxygen applied or refused. R47's Progress Note dated 10/1325 at 05:22 AM documented R47's eyes were closed. Staff educated R47 they were going to readminister his oxygen as his oxygen saturation was 52 percent on room air. Staff applied oxygen at 3 liters, and R47's oxygen saturation increased to 84 percent. His lower extremities were warm to the touch, but his bilateral legs were dark purple. The note lacked documentation that the provider was called about the discoloration. R47's Progress Note dated [DATE] at 00:07 AM documented R47 did not wake up when vital signs were assessed; his oxygen saturation was 82 percent at 3 liters. R47's lips continued to be dark purple, and he had mottling (blotchy, red-purplish marbling of the skin near the end of life caused by slow blood circulation) noted all over areas of his body. R47 had increased confusion and asked where he was, and reported he had never seen that room before. The note lacked documentation the provider was called with a change in condition. R47's Progress Note dated [DATE] at 04:54 AM documented R47 had continuous oxygen on throughout the night. R47 would remove his oxygen, and his oxygen saturation on room air ranged from 57 to 73 percent. Staff encouraged R47 to keep his oxygen on and let staff help put it back on. R47 had a cough. Staff repositioned him during the night, and he rested comfortably. His lung sounds were audibly gurly'[sic]. His respirations increased to 26 with a rise and fall of his chest. At 04:10 AM, R47's respirations were shallow and slow, and within a few minutes, the resident passed peacefully. He had no audible heart rate, radial heart rate, or jugular heart rate noted, and no respirations. R47 expired at 04:21 AM. Staff contacted the provider and received orders. During an interview on [DATE] at 06:10 AM, Licensed Nurse (LN) I reported that if a resident had a change in condition, she would notify Physician HH and then notify Administrative Nurse D. LN I reported that she did not document in R47's EMR when he had changes in condition and reported that Administrative Nurse D knew about the changes and Administrative Nurse D had contacted Physician HH. During an interview on [DATE] at 02:28 PM, Administrative Nurse D reported she expected staff (continued on next page)

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	17E210	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Access Mental Health	500 Peabody Peabody, KS 66866

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to document in the residents' EMR when a provider was contacted for a change in condition. Additionally, Administrative Nurse D reported that R47's EMR should have had documentation when he refused to go to the hospital for evaluation. Administrative Nurse D reported she updated the provider with R47's changes. During an interview on [DATE] at 08:35 AM, Physician HH reported the staff had contacted her when R47 had a change in condition, and she expected the staff to document in the resident's EMR when staff contacted a physician and the physician's response. The facility did not provide a policy for professional standards related to the documentation of care provided.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 42 residents. The sample included 12 residents, with one resident reviewed for catheters (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Based on observation, record review, and interviews, the facility failed to ensure adequate catheter care within the standards of practice was provided for Resident (R) 1 when staff failed to secure the catheter tubing to R1's leg to prevent pulling and/or dislodgement and also failed to provide catheter care using adequate infection control practices to prevent catheter related urinary tract infections (UTI).Findings included:- R1's Electronic Health Record (EHR) for R1 included diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and neuropathic bladder (a condition where bladder control is impaired due to damage or dysfunction in the nervous system).R1's Annual Minimum Data Set (MDS), dated 10/09/25, documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R1 had hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue, persistent belief or perception held by a person although evidence shows it was untrue), and an indwelling catheter. The assessment documented R1 did not display behaviors that qualified as rejection of care.R1's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 10/09/25, documented R1 had a catheter in place due to neurogenic (neuropathic) bladder.R1's Quarterly MDS, completed on 07/28/25, documented a BIMS score of 15, which indicated intact cognition. The assessment documented R1 had hallucinations, delusions, and an indwelling catheter. The assessment documented R1 rejected care for four to six days during the look-back period.R1's Care Plan, initiated 09/14/25 and revised on 12/09/25, documented R1 had a catheter for the management of a neurogenic bladder, initiated on 10/05/25 and revised on 02/29/24. The plan documented that he had a catheter that was 14 or 16 French with an undocumented balloon size bulb, and a leg bag (a small urine collection bag that is attached to a catheter and worn on the leg), and staff provided the following interventions:Staff would change monthly and as needed, and staff would drain the bag every two to three hours and as needed, initiated on 10/05/23 and revised on 12/09/25.Staff would monitor and document intake and output in accordance with facility policy; R1 did attempt to empty the leg bag without staff assistance, initiated on 10/05/23 and revised on 11/06/23.Staff would monitor and document any pain/discomfort associated with the catheter, initiated on 10/05/23Staff would monitor, record, and report to the physician any signs or symptoms of a UTI, such as pain, burning, blood-tinged urine, cloudiness, lack of urine output, deepening of urine color, foul-smelling urine, fever, altered mental status, or behavioral changes, initiated on 10/05/23.Nursing staff would assess R1's catheter for tubing kinks each shift and as needed; R1 did have behaviors of fidgeting with the tubing and/or collection bag. If R1's clothing was wet, the nurse would assess the catheter, initiated on 10/05/23, revised on 11/20/24.R1 was resistant to catheter care and staff assistance to empty his leg bag. Behaviors included emptying it himself, not completely closing the valve, or utilizing clean procedures. Staff would encourage R1 to allow staff to assist him in relation to infection control and proper techniques, initiated on 02/08/24 and revised on 11/20/24.Staff would use 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 draining or emptying the catheter leg bag, initiated on 01/14/25 and revised on 12/09/25.R1 Care Plan did not include any evidence of failed or resolved interventions regarding the use of a securement device for catheter tubing.R1's EHR Orders tab revealed the following physician orders:Foley (a brand of catheter) catheter (14-16 French) (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in place to leg bag, change every 28 days related to neuropathic bladder, dated 01/10/25 at 09:00 AM.Empty the leg bag four times every day and as needed, every two hours related to neuropathic bladder, initiated 11/21/23 at 08:00 PM.R1's EHR under the Progress Notes tab, reviewed from 08/01/25 to 12/09/25, lacked documentation related to the application of a leg securement device/safety anchor on the catheter or catheter tubing. The record lacked entries of any failed attempts to utilize a leg securement device/safety anchor.During an observation on 12/08/25 at 09:25 AM, R1 was in his room with a catheter leg bag concealed under his left pant leg. The bag appeared full and bulging. R1 stated he would alert staff to allow them to assist in emptying the leg bag.During an observation on 12/08/25 at 11:27 AM, no change from the previous observation of R1's leg bag.During an observation on 12/09/25 at 09:34 AM, R1 ambulated in the hallway and had appropriate interactions with peers and staff.During an observation on 12/09/25 at 01:17 PM, Certified Nurse Aide (CNA) M emptied R1's leg bag into an empty urinal. CNA M entered the room, performed hand hygiene, and applied appropriate EBP. CNA M then emptied the urine collection bag and allowed the drain port of R1's leg bag to come in contact with the side of the urinal. CNA M did not clean or sanitize the drain port pad after emptying the contents of the drain bag. CNA M did not place a cap or other barrier device over the end of the drain port on the leg bag. R1 complained that the catheter was pulling. CNA M removed the EBP and performed hand hygiene, then consulted with Licensed Nurse (LN) G. CNA M re-entered R1's room and readjusted R1's leg bag without reapplying the appropriate EBP or performing hand hygiene.During an interview on 12/09/25 at 11:27 AM, CNA M said R1 had a catheter, and CNA staff should empty the catheter drain bag every two hours and clean the catheter tubing every two hours when the drain bag is emptied. CNA M said the CNA staff documented the output on a piece of paper, then gave it to the nurse to chart on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). During an interview on 12/09/25 at 12:52 PM, LN G stated R1 had a catheter, and CNA staff were responsible for cleaning the catheter and emptying the drainage bag; the tasks should be performed every two hours. LN G said R1 was able to clean and empty the drainage bag, although it was the responsibility of the staff. LN G said training has been attempted with R1 for the correct procedure to clean and empty the drainage bag, although it is not certain if R1 retained the training. R1 sometimes allowed the staff to assist in the draining and cleaning of his leg bag. LN G stated the CNA staff would document R1's urine output on a piece of paper and give it to the nurse, who then documented it in the EHR on the MAR/TAR. During an interview on 12/09/25 at 01:41 PM, CNA M denied any knowledge of any type of securement device for R1's catheter tubing. CNA M confirmed she did not sanitize or clean the drainage port on R1's catheter bag. CNA M stated she did not utilize the appropriate EBP when adjusting R1's leg bag. CNA M stated that nurses performed catheter care on shower days.During an interview on 12/19/25 at 01:45 PM, Administrative Nurse D revealed the facility did not utilize or order securement devices for catheters because R1 was the only resident in the facility with a catheter and stated R1 would not allow the devices or anchors to be utilized.During an interview on 12/10/25 at 09:45 AM, Administrative Nurse D revealed that nurses were responsible for the insertion and changing of catheters, and CNA staff were responsible for emptying and cleaning the catheters. Administrative Nurse D revealed that catheter cleaning was performed with showers and should be performed with soap and water only. Administrative Nurse D reported that the facility does not utilize catheter securement devices since R1 would not allow them to be used. Administrative Nurse D verified she had no documentation of R1's refusal of a securement device for the tubing or of any failed attempts to secure the tubing. Administrative Nurse D reported that when a leg bag was being emptied, the drain spout should not come into contact with the urinal and should have been cleaned with an isopropyl alcohol wipe before the spout was placed in the stowed position.The facility's undated Westview Manor of [NAME] Foley Catheter Care policy documented that catheter care would be provided at least twice daily and more often as needed. The policy documented that the catheter should be taped or anchored to the upper thigh to avoid tension on the catheter. The drainage bag (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be emptied at the end of each shift, or more often if needed, into a measured container with the total documented in the EHR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 42 residents. Based on observation, record review, and interviews, the facility failed to implement and maintain an effective infection control program when staff failed to provide catheter care using adequate infection control practices and failed to implement 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) during high contact care for Resident (R)1.Findings Included:- During an observation on 12/09/25 at 01:17 PM, Certified Nurse Aide (CNA) M emptied R1's leg bag into an empty urinal. CNA M entered the room, performed hand hygiene, and applied appropriate EBP. CNA M then emptied the urine collection bag and allowed the drain port of R1's leg bag to come in contact with the side of the urinal. CNA M did not clean or sanitize the drain port pad after emptying the contents of the drain bag. CNA M did not place a cap or other barrier device over the end of the drain port on the leg bag. R1 complained that the catheter was pulling. CNA M removed the EBP and performed hand hygiene, then consulted with Licensed Nurse (LN) G. CNA M re-entered R1's room and readjusted R1's leg bag without reapplying the appropriate EBP or performing hand hygiene.During an interview on 12/09/25 at 01:41 PM, CNA M confirmed she did not sanitize or clean the drainage port on R1's catheter bag. CNA M stated she did not utilize the appropriate EBP when adjusting R1's leg bag. CNA M stated that nurses performed catheter care on shower days.During an interview on 12/10/25 at 09:45 AM, Administrative Nurse D said catheter cleaning was performed with showers and should be performed with soap and water only. Administrative Nurse D reported that when a leg bag was being emptied, the drain spout should not come into contact with the urinal and should have been cleaned with an isopropyl alcohol wipe before the spout was placed in the stowed position. Administrative Nurse D outlined the use of appropriate EBP while staff were emptying or manipulating the urine drainage system or any of its components. The facility did not provide a policy related to Enhanced Barrier Precautions.The facility's undated Westview Manor of [NAME] Infection Surveillance policy documented that surveillance in the facility was accomplished by reviewing and implementing systems for infection control and prevention that complied with facility policies and procedures and evidence-based best practices. The facility would measure outcomes or systems that included compliance with infection control practices, including catheter care.