STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E242	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Hospital Onaga Ltcu	206 Grand Avenue St Marys, KS 66536

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 23 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to fully complete the Comprehensive Minimum Data Set (MDS) for Resident (R) 3 when staff did not complete an analysis for triggered Care Area Assessments (CAA). This placed this resident at risk for an inaccurate plan of care and unidentified care needs. Findings included: - R3's Electronic Medical Record (EMR) documented diagnoses of mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), dementia (a progressive mental disorder characterized by failing memory and confusion), weakness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hemiplegia (paralysis of one side of the body), hypertension (HTN-elevated blood pressure), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R3's Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated a severely impaired cognition. R3 had impairment on both sides of his upper and lower extremities. R3 required the use of a Broda chair (specialized wheelchair with the ability to tilt and recline) for mobility. R3 was dependent on staff for all functional abilities. R3 was always incontinent of bowel and bladder. R3 required enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). R3's Care Area Assessment (CAA) dated 01/20/24 triggered for cognitive loss/dementia, communication, urinary incontinence, psychotropic (alters mood or thought) drug use, visual function, dehydration/fluid maintenance, feeding tube (tube for introducing high-calorie fluids into the stomach), pressure ulcer, pain, nutritional status, and dental care. All triggered CAA lacked completion with analysis of findings. R3's Care Plan revised on 04/17/23 documented that staff would provide care to R3 to maintain appearance, hygiene, and skin integrity. R3's plan of care documented R3 received meals via percutaneous endoscope gastrostomy (PEG-a tube inserted through the wall of the abdomen directly into the stomach). R3's plan of care documented she was incontinent of bowel and bladder. (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 09:34 AM R3 was reclined in her Broda chair, with her eyes shut. On 10/31/24 at 12:08 PM Administrative Nurse D stated she was unaware the CAA needed to be filled out. She stated she was told they were optional and only needed to be filled out if she needed to use them for the care plan. She stated she had been doing the MDS for three years and had just received training. She stated she had learned each triggered CAA needed resident analysis documentation. The updated facility Comprehensive Assessment policy reviewed 02/2019 documented the facility would conduct initial and periodic comprehensive, accurate, standardized, reproducible assessments of each resident's function capacity. The assessment process would include direct observation and communication with the resident and responsible party and family, as well as communication with licensed and non-licensed direct care staff members from all departments on all shifts. The resident assessment instrument (RAI) system developed by the federal government would be used as the basis for the assessment, care planning, and documentation system. The facility failed to ensure staff fully completed the Comprehensive MDS for R3 when staff did not complete the triggered CAA. This placed R3 at risk for an inaccurate plan of care and unidentified care needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 23 residents. The sample included 12 residents with six residents reviewed for falls and accidents. Based on observation, record review, and interviews, the facility failed to consistently implement interventions to prevent falls for Resident (R)19 who had multiple falls. This deficient practice placed R19 at risk for further falls and related injuries. Findings included: - R19's Electronic Medical Record (EMR) from the Diagnoses tab documented restlessness and agitation, frontotemporal neurocognitive disorder (a group of disorders that occur when nerve cells in the frontal and temporal lobes of the brain are lost), and pain. The Quarterly Minimum Data Set (MDS) for R19 dated 09/07/24 recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R19 had two falls since admission with no evidence of injury and two falls with injury, skin tears, abrasions, and bruising. The MDS documented that R19 was dependent on staff for bathing, toileting, and dressing. R19's Falls Care Area assessment dated [DATE] documented that staff were to monitor R19's wandering and assist him with walking. Staff were to walk alongside him in times of wandering. Staff were to accompany R19 to all areas and ensure his needs were met. Nursing was to implement fall precautions and follow facility fall protocol. R19's Care Plan dated 03/14/24 documented R19 was a fall risk related to his wandering and stated a goal that he would not sustain serious injury throughout his stay. Staff were to ensure R19's call light was always near him, while he was in his room. Staff was to provide a low-stimulation environment, follow facility fall protocol, and keep the tray table away from R19's path when staff were not supervising. R19's plan of care dated 07/15/24 documented R19's family and hospice provider agreed to stop doing neurological assessments and vital sign checks after falls, related to R19's increased agitations. R19's plan of care dated 09/09/24 documented that staff were to be one-to-one with R19 when he was walking. Staff were to ensure a fall-hazard-free environment, adequate lighting, and proper footwear. The plan directed to make sure there were no trip hazards, ensure the floor was clean and dry, and ensure R19's blankets were not wrapped tightly around his lower extremities while he was in bed. R19's EMR under Nursing Notes documented non-injury falls on 08/26/24, 09/02/24, 09/08/24, 09/14/24, 09/26, 10/15, and 10/18/24. R19's EMR under Nursing Note dated 9/02/24 documented that a nurse was assisting R19 in his room, and R19 was settled sitting back on his bed. The nurse left the room to complete a treatment across the hall, as they exited the treatment room, the resident was heard groaning. The nurse entered the room to find the resident lying on the floor with his head on the trash can. R19 had a blanket and shoes on, his call light was within reach. R19 did not have a visible injury. Staff lifted R19 and put him back on the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's clinical record lacked evidence an intervention was implemented in response to the 09/02/24 fall. R19's EMR under Nursing Note dated 9/05/24 documented that R19 was found on the floor. He was relaxed and appeared to have no signs of pain or distress. He was wearing blankets around his back and was resting his back against the wall and headboard. Staff used a Hoyer (total body mechanical lift) to lift R19 into the bed. R19 had been aggressive during position changes due to advanced dementia. R19 also demonstrated poor awareness. Due to R19's dementia, the resident was unable to communicate complex thoughts, though he showed his expressions well, and when he was frustrated, he became visibly agitated and aggressive to staff. R19's family requested orders not to attempt to obtain vital signs if the resident was agitated or aggressive. R19's clinical record lacked evidence an intervention was implemented in response to the 09/05/24 fall. R19's EMR under Nursing Note dated 9/14/24 documented that R19 was found on the floor. He was sitting on the floor in front of his chair, had his left arm bent behind him, his back leaning against the right front of the chair, with his left back against the chair. The resident did not show any signs of distress. The Certified Nurse Aide (CNA) suggested that he slid off the chair and stated R19 was sitting in the chair before his fall. Staff performed range of motion with no apparent signs of pain. Staff assisted R19 to a standing position and he did not show any signs of pain with weight bearing. R19's clinical record lacked evidence an intervention was implemented in response to the 09/12/24 fall. R19's EMR under Nursing Note dated 9/26/24 documented R19 was found lying on his left side in front of his recliner in his room. The CNA staff reported they had assisted R19 with incontinence care as he had a bowel movement. R19 was resistive during care, at some point, he got himself up from his bed and fell . An initial assessment showed no signs of major injury other than a 0.5-centimeter (cm) skin tear to the left elbow. R19 did not want to sit after his fall so he was assisted to sit out on the patio with staff and was taken for a short walk. R19's clinical record lacked evidence an intervention was implemented in response to the 09/26/24 fall. R19's EMR under Nursing Notes dated 10/15/24 documented that R19 had an unwitnessed fall in his room. He was sitting upright in front of the closet door. Staff assessed and noted there were no signs of injury. Staff obtained R19's vital signs, and all vital signs were within his normal baseline. The note documented staff spoke to the hospice nurse concerning the fall. R19's clinical record lacked evidence an intervention was implemented in response to the 10/15/24 fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's EMR under Nursing Notes dated 10/18/24 documented the nurse was called to R19's room. The CNA staff reported that they heard R19 yelling and upon entering R19's room, he was on the floor. R19 lay on his left side, with his head angled towards the window and closet corner. His feet were in the direction of the door. Staff provided comfort and R19 was not yelling when the nurse entered his room. Staff assisted R19 to stand and he became agitated, which was his baseline. The note documented R19 was more agitated than usual, likely from generalized pain from the fall and the need for the nurse to approximate skin tears. R19 seemed to want to wander; he was assisted to his wheelchair and staff wheeled him around, which tended to provide R19 some comfort. R19's clinical record lacked evidence an intervention was implemented in response to the 10/18/24 fall. On 10/29/24 at 09:07 AM R19 sat in the chair in his room with a pillow behind him, covered with a blanket. On 10/30/24 at 09:42 AM R19 sat in the chair in his room. His breakfast tray sat on the TV stand in front of him. On 10/31/24 at 11:24 AM Licensed Nurse (LN) G stated an intervention was put in place anytime a resident had a fall. She stated if an intervention was not put in at the time of the fall, staff would add one after stand-up or after a team huddle. On 10/31/24 at 11:53 AM, CNA M stated fall interventions could be viewed on the resident's care plan. She stated the CNA and the nurses would have a team huddle after a resident fell and decide on an intervention as a team. On 10/31/24 at 12:08 PM Administrative Nurse D stated the nurse on duty should implement a fall intervention after a team huddle. She stated if the nurse was unsure what intervention should be implemented, the nurse should add to the care plan that they would call the director for ideas. On 10/31/24 at 12:11 PM Administrative Nurse A stated the facility had been working on interventions for R19's falls. Administrative Nurse A stated the facility had a performance improvement project (PIP) dated 09/09/24 started. Administrative Nurse A stated the facility would continue working with family and staff on fall interventions. The facility's Accident and Incident Documentation documented that when an elder experiences an incident or accident, the nurses caring for the elder would record the elder's response for at least 72 hours or until the elder's condition was stabilized. The elder's physician or designated physician would be informed of the incident or accident. The information provided to the physician would be recorded in the interdisciplinary notes. The facility failed to identify and implement interventions to prevent further falls for R19. This deficient practice placed R19 at risk for further falls and related injuries.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 49634 The facility identified a census of 23 residents. The sample included 12 residents with one resident reviewed for hospice. Based on observation, record review, and interviews, the facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for Resident (R) 19. This deficient practice placed R19 at risk for impaired end-of-life care. Findings Included: - R19's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of documented restlessness and agitation, frontotemporal neurocognitive disorder (a group of disorders that occur when nerve cells in the frontal and temporal lobes of the brain are lost), and pain. The Quarterly Minimum Data Set (MDS) for R19 dated 09/07/24 recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R19 was dependent on staff for bathing, toileting, and dressing. The MDS documented that R19 received hospice services during the observation period. R19's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/13/24 documented the resident was on hospice, related to cognitive loss and dementia (a progressive mental disorder characterized by failing memory and confusion). The CAA documented that R19's plan of care would include ways to provide support and comfort to R19, decrease his agitation and anxiety, and provide comforting activities that the resident enjoys. R19 was unable to answer assessment questions appropriately. R19 becomes easily agitated and cannot follow prompts for answers related to advanced dementia. R19's Care Plan dated 03/12/24 documented R19 had a terminal prognosis related to dementia and was receiving hospice services. Staff were to administer medications for anxiety and comfort as ordered. Staff were to allow R19 and his family to share worries, concerns, and feelings. The facility would arrange time for spiritual and religious practice. Staff were to contact hospice and family upon observed changes. Staff was to encourage visitors and encourage R19 to interact with visitors and other residents as much as possible. Hospice was to provide bathing, oral care, peri-care, companionship, and family support. Staff was to observe R19 closely for signs of pain, administer pain medications as ordered, and notify the physician immediately if there is breakthrough pain. Staff were to see the hospice calendar in R19's binder at the nurse's station for the hospice visit schedule. Nursing was to contact hospice if R19 needed additional visits or supplies. The care plan lacked contact information for the hospice provider and lacked information regarding the frequency of visits, the supplies, equipment, and medications provided by the hospice. A review of the hospice-provided binder revealed that R19 was admitted to hospice services on 03/05/24. On 10/29/24 at 09:07 AM R19 sat in the chair in his room, with a pillow behind him, covered with a blanket. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 11:24 AM Licensed Nurse (LN) G stated there should be collaboration of care between the facility and hospice and said staff should be able to open the resident's care plan and know what the hospice provider provides for the resident, and what the facility provides for the resident. On 10/31/24 at 11:53 AM Certified Nursing Aide (CNA) M stated if she needed to know when the nurse or aide for a resident on hospice was going to be at the facility, she would find that information in the resident's hospice binder. She stated she was unsure what supplies the hospice provided, or what equipment. CNA M stated she would ask her charge nurse. On 10/31/24 at 12:08 PM Administrated Nurse D stated that administrative staff know what equipment each hospice resident has. She stated if the resident ran out of hospice supplies, the resident would just use the facility's supplies. Administrative Nurse D said she was unsure what medications should be part of the care plan. The facility's Hospice Services policy documents each resident will receive, and this facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The facility provides continuity of care to provide residents who are terminally ill with the opportunity to receive comprehensive, interdisciplinary care that recognizes their spiritual needs and to assist residents, family members, and friends to live as fully and completely as possible with meaning and dignity. Residents and family members and friends may be offered hospice care upon request of the resident and families and or guardians to meet care and services needs which is consistent with the expressed preferences of the resident's family members and or guardians. The facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for R19. This deficient practice placed R19 at risk for impaired end-of-life care.