STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E580	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Lodge	300 W 3rd Coldwater, KS 67029

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. The facility reported a census of 23 residents. Based on observation, interview and record review, the facility failed to provide Registered Nurse (RN) coverage for at least eight continuous hours daily. Finding includes:- The facility's Daily Census Report, dated 09/21/25, documented 23 residents resided in the facility.Review of nursing schedules for 04/01/24 through 12/31/24 revealed a lack of RN coverage for eight continuous hours on 04/28/24, 05/11/24, 05/25/24, 06/01/24, 06/22/24, 06/23/24, 07/06/24, 07/07/24, 07/20/24, 07/21/24, 08/03/24, 08/04/24, 08/17/24, 08/18/24, 08/31/24, 09/01/24, 09/14/24, 09/15/24, 10/26/24, 10/27/24, 11/23/24, 11/24/24, and 12/21/24.Review of RN payroll documents for 04/01/24 through 12/31/24 revealed a lack of RN coverage for eight continuous hours on 04/28/24, 05/11/24, 05/25/24, 06/01/24, 06/22/24, 06/23/24, 07/06/24, 07/07/24, 07/20/24, 07/21/24, 08/03/24, 08/04/24, 08/17/24, 08/18/24, 08/31/24, 09/01/24, 09/14/24, 09/15/24, 10/26/24, 10/27/24, 11/23/24, 11/24/24, and 12/21/24.On 09/21/25 at 10:30 AM, observation revealed 23 residents resided in the facility.During an interview on 09/22/2025 at 03:43 PM, Administrative Staff A stated that the facility did not have RN coverage on the days listed. Administrative Staff A stated the facility had identified this issue and had since improved.The facility did not provide a policy for RN coverage.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. The facility reported a census of 23 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 09/21/25 at 09:20 AM revealed the following areas of concern:Dry Storage Area:Several storage bins filled with a variety of pasta with no date or label.Free-standing freezer:One bag of French toast sticks with no date or label.Several bags of English muffins with no date.One bag of garlic bread with no date or label.One bag of chicken patties, no date or label.One bag of chicken legs with no date or label.Several bags of ground beef and pork sausage, no date.One bag of pepperoni, no date.One bag of unidentified meat, no date or label.Free-Standing refrigerator:Three opened gallons of milk, no date.One opened bottle of tartar sauce, no date.One opened container of Parmesan cheese, no date.Three-bay Refrigerator:Old dried blood on the bottom of the refrigerator.One opened bag of lunch meat with no date.One large bag of opened shredded cheese, no date.One plastic container of tomato sauce, no date or label.One plastic container of red Jello, no date or label.Several unsealed wrinkled black-brown colored tomatoes.Several unsealed wrinkled green peppers.One bag of wilted brown lettuce, no date.Three packaged bags of ground beef in a metal container were observed thawing above the stove, which contained two pans of cut-up potatoes cooking.One packaged bag of ground pork sausage in a metal container, thawing above the stove, that contained two pans of cut-up potatoes cooking.Two packaged bags of ham lunch meat in a metal container, thawing above the stove, that contained two pans of cut-up potatoes cooking. The lunch meat was soft and warm when touched.During an interview on 09/21/25 at 09:40 AM, Dietary Staff CC reported that all food items in the freezer, dry storage, and refrigerator required to be sealed, labeled, and dated when opened. Dietary Staff CC reported that this was how he thawed the meats that were on the menu to be prepared.During an interview on 09/22/25 at 10:36 AM, Dietary Staff BB, Certified Dietary Manager, stated she expected the staff to label, date, and seal all food items. Dietary Staff BB stated she expected the staff to keep all areas of the kitchen clean. Additionally, Dietary Staff BB stated she expected staff to thaw all meats the correct way.During an interview on 09/23/25 at 11:40 AM, Administrative Staff A stated he expected all food items to be stored, sealed, labeled, and dated properly. Administrative Staff A stated she expected the dietary staff to thaw out all meats appropriately.The facility's policy Food Preparation and Handling dated 01/13/2016, states that all food items and products served to elders would be prepared from the central kitchen using methods and techniques designed to preserve maximum nutritive value and be free of injurious organisms and substances. The kitchen equipment would be kept clean. Food items would be checked, dated, and stored properly. Defrosting of food would be completed by placing the frozen item in the refrigerator until thawed or placing it in a cold-water bath for defrosting.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility reported a census of 23 residents. Five Certified Nurse Aide (CNA) staff who worked in the facility for more than 12 months were reviewed for the required in-service training. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for CNA staff with the required topics and no less than 12 hours per year. Findings included:- Review of CNA personnel files revealed the following:CNA M, who was hired for the facility on 02/26/1997, lacked the total hours calculated for the 12 hours required.CNA N, who was hired 10/24/23, lacked the total hours calculated for the 12 hours required.CNA O, who was hired 08/29/17, lacked Abuse, Neglect, and Exploitation (ANE) and social media training. CNA O's total hours were not calculated for the 12 hours required.During an interview on 09/23/25 at 09:00 AM, Administrative Staff A reported he expected the staff to have the required education and the required 12 hours annually.The facility did not provide a policy for CNA staff required for in-service and annual training hours.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 23 residents; the sample included 14 residents. Based on interview and record review, the facility failed to inform Resident (R) 18, R6, R9, R5 and R15 and/or their representative regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included:- Review of both Electronic Medical Record (EMR) and paper records revealed the following:R18's July 2025 Medication Administration record (MAR) documented an order for escitalopram oxalate (antidepressant medication used to treat mood disorders) five milligrams (mg) daily, dated 07/29/25 (discontinued on 09/08/25). R18's clinical record lacked evidence of informed consent related to the medication.R6's September 2025 MAR documented orders for divalproex sodium (anticonvulsant used for psychotropic properties to address mood and behavior) 125 mg at bedtime for major depressive disorder (major mood disorder that causes persistent feelings of sadness) dated 02/20/25 and Seroquel (antipsychotic medication) 300 mg at bedtime for psychotic disorder (major mental disorder characterized by a gross impairment in reality perception) dated 09/25/24. R6's clinical record lacked evidence of informed consent related to the medications.R9's September 2025 MAR documented orders for alprazolam (antianxiety medication) 0.25 mg each evening for anxiety, dated 04/24/25, and Zoloft (antidepressant) 25 mg, dated 07/23/25. R9's clinical record lacked evidence of informed consent related to the medications.R5's EMR documented an order for risperidone 0.5 mg twice daily for dementia (a progressive mental disorder characterized by failing memory and confusion) dated 03/05/24. R5's clinical record lacked evidence of informed consent related to the medication.R15's EMR documented orders for Seroquel 100 mg at bedtime for borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior) dated 12/04/23; divalproex sodium 125 mg at bedtime for borderline personality disorder dated 12/04/23; olanzapine (antipsychotic medication) 20 mg at bedtime for borderline personality disorder dated 12/04/23; escitalopram 20 mg for depression dated 12/04/23 and clonazepam (benzodiazepine medication) 0.5 mg twice a day for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) dated 12/04/23. R15's clinical record lacked evidence of informed consent related to the medications.During an interview on 09/22/25 at 03:01 PM, Administrative Nurse D reported that the facility did not complete consents for psychotropic medications unless the resident started a new medication.The facility's policy Psychotropic Medication Use dated 01/09/25, documented that every psychoactive medication will initiate a signed Informed Consent to ensure the physician has reviewed with the resident and/or resident representative the potential adverse effects of the order of any psychoactive medication.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility reported a census of 23 residents. Based on observation, and interview, the facility failed to ensure that meals were served at safe and appetizing temperature. This was evident of a one of one meal observation.Findings included:- During an observation on 09/22/25 at 10:42 AM, Dietary Staff DD prepared three servings of pureed sausage, onions, and peppers that had a cooked temperature of 165 degrees Fahrenheit (F). Dietary Staff DD pureed the food, and the temperature after preparation was 127 degrees F. Dietary Staff DD placed the pureed sausage in three separate, divided dishes and covered the dishes with foil. Dietary Staff DD prepared the pureed potatoes that had a cooked temperature of 186 degrees F. Dietary Staff checked the potatoes' temperature after they were pureed at 135 degrees F. Dietary Staff DD uncovered the three divided dishes and placed the pureed potatoes into the dish, and covered the dishes with foil that remained on the counter in the kitchen until 11:00 AM, when Dietary Staff DD placed the three divided dishes of prepared pureed food in the steam table.During an observation on 09/22/25 at 11:30 AM, Dietary Staff DD re-temped the pureed food that was on the steam table. The pureed potatoes' temperature was 115 degrees F., and the pureed sausage temperature was 120 degrees F. Dietary Staff DD served the pureed foods to the residents at those recorded temperatures.During an interview on 09/22/25 at 01:05 PM, Dietary Staff BB stated she expected staff to serve all food items at the required holding temperatures of 135 degrees F. for hot food.During an interview on 09/23/25 at 11:40 AM, Administrative Staff A stated she expected the dietary staff to serve food at the appropriate temperatures.The facility's policy Food Preparation and Handling dated 01/13/2016, states that all food items and products served to elders would be prepared from the central kitchen using methods and techniques designed to preserve maximum nutritive value and be free of injurious organisms and substances. The facility's policy lacked the temperature requirements for cooked and holding food.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. The facility reported a census of 23 residents; the sample included 14 with two residents reviewed for positioning and mobility. Based on observation, interview, and record review, the facility failed to provide a footboard or footrests for Resident (R) 3 and R9. Findings included:- R3's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and pain.R3's 04/14/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of zero, which indicated severely impaired cognition. R3's MDS recorded impairment to one side of R3's lower extremity. The MDS recorded R3 required total dependence of all activities of daily living. The 04/17/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R3 did not answer any questions. R3 was sometimes able to communicate nonverbally.R3's Care Plan instructed staff to provide a high-back wheelchair with anti-tip bars and to propel the wheelchair for the resident, dated 04/09/24. The plan instructed staff to provide total staff assistance for locomotion via a manual high back wheelchair, dated 05/29/25.R3's Progress Note on 07/09/25 at 09:09 PM documented the resident tolerated a restorative program for positioning in a wheelchair.During an observation on 09/22/25 at 08:56 AM, R3 sat in a wheelchair at the nurses' station with no footrests. R3's feet were dangling approximately two inches off the ground.During an observation on 09/22/25 at 09:00 AM, Certified Nurse Aide (CNA) N propelled R3 down the hallway in her wheelchair to the shower room. R3's feet dangled off the ground.During an observation on 09/22/25 at 12:04 PM, R3 was in the dining room in her wheelchair. The tips of R3's toes touched the floor. R3 was unable to place her feet on the ground.During an observation on 09/23/25 at 08:30 AM, R3 sat in a wheelchair with no footrests. R3's feet were dangling approximately two inches off the ground.During an interview on 09/23/25 at 10:15 AM, CNA P reported that R3 did not have foot pedals for her wheelchair and that R3's toes would only touch the ground sometimes. CNA P reported that R3 used to have foot pedals, but they caused her pain when the staff would have to bend her knee to place her feet on the foot pedals. CNA P reported that R3 could not self-propel her wheelchair or adjust herself in the wheelchair.During an interview on 09/23/25 at 11:27 AM, Certified Restorative Aide (CRA) M reported that she believed the facility staff had tried foot pedals on R3's wheelchair in the past, and it would not work as she would cross her feet, and they would fall behind the wheelchair legs. CRA M reported that R3 had a footboard at one time to keep her feet positioned and was unsure why R3 no longer had that footboard. CRA M reported that when she worked with the residents on the restorative program, she would look at how the residents' body was positioned but not their feet.During an interview on 09/23/2025 at 11:46 AM, Licensed Nurse (LN) G reported that she really did not know of any residents who had no foot pedals that could not self-propel.During an interview on 09/23/25 at 12:25 PM, Administrative Nurse D stated she expected that residents who were not able to self-propel independently in their wheelchairs would have footrests. - R9's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).R9's 01/20/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of two, which indicated severely impaired cognition. R9's MDS recorded R9 required total dependence for most activities of daily living, which included total dependence on staff with transfers and wheelchair mobility.The 01/24/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R9 had dementia, and R9 was alert and generally able to make needs known to staff.R9's Care Plan plan instructed staff to provide total staff assistance for locomotion via a wheelchair, dated 01/22/25.R9's Progress Note on 04/18/25 at 10:25 AM documented the resident required one staff member's assistance for wheelchair mobility.During an observation on 09/21/25 at 12:30 PM, R9 sat in a wheelchair in her room, with no footrests. R9's feet were dangling (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately two inches off the ground.During an observation on 09/22/25 at 12:04 PM, R9 was in the dining room in her wheelchair. The tips of R9's toes touched the floor. R9 was unable to place her feet on the ground.During an interview on 09/23/25 at 10:15 AM, Certified Nurse Aide (CNA) P reported that R9 never had foot pedals for her wheelchair, and CNA P reported that R9's feet dangle all the time when R9 is in her wheelchair. CNA P reported that R9 could not self-propel her wheelchair or adjust herself in the wheelchair.During an interview on 09/23/25 at 11:27 AM, Certified Restorative Aide (CRA) M reported that R9 never had foot pedals on her wheelchair, and she was unaware why. CRA M reported that when she worked with the residents on the restorative program, she would look at how the residents' body was positioned but not their feet.During an interview on 09/23/2025 at 11:46 AM, Licensed Nurse (LN) G reported that she really did not know of any residents who had no foot pedals that could not self-propel.During an interview on 09/23/25 at 12:25 PM, Administrative Nurse D stated she expected that residents who were not able to self-propel independently in their wheelchairs would have footrests.The facility's policy Restorative Plan f-or Wheelchair Mobility dated 01/09/25, documented each elder using a wheelchair as a mobility device must be provided with individualized measurements for appropriate wheelchair size position elder in 90-90-90 position, foot support, do not allow feet to dangle Provide appropriate foot support.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 23 residents; 14 residents were sampled for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person could not make their own decisions). Based on interview and record review, the facility failed to ensure two resident's advanced directives were accurately reflected when Resident (R) 2 had a Do Not Resuscitate (DNR- or no code, a legal document or order that means the person does not desire resuscitative measures) form completed but had an order for a full code. Additionally, R3's DNR lacked a resident/responsible party and witness signature. R14 declined a DNR in 2016, and the facility had a DNR order.Findings included:- Review of R2's Physician Order in the Electronic Medical Record (EMR) recorded an order for Full Code dated [DATE]. R2's Care Plan staff instructed to provide CPR dated [DATE]. Review of R2's EMR revealed a DNR signed by R2 on [DATE] and by a physician on [DATE].R3's Physician Order in the EMR recorded an order for DNR dated [DATE]. R3's DNR documented a physician's signature only, dated [DATE], but lacked a witness, representative, and/or resident signature.R14's Physician Order in the EMR noted an order for DNR dated [DATE]. R14's Care Plan staff instructed that R14 had a signed DNR in her EMR. Review of R14's EMR revealed R14 signed a document stating they do not agree to a DNR on [DATE]. Additionally, the provider did not check off DNR and signed the acknowledgement on [DATE].During an interview on [DATE] at 12:07 PM, Administrative Nurse D stated the Social Service Designee (SSD) X would complete the advanced directive paperwork, and the floor nurse would document the order in EMR. Administrative Nurse D stated she expected all residents would have the correct paperwork completed, care planned, and ordered.The facility did not provide a policy on advance directives.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 23 residents. The sample included 14 residents with one resident reviewed for nutrition. Based on observation, record review, and interview, the facility failed to notify the representative of changes in weight for Resident (R) 1. Findings included:- R1's Electronic Medical Record (EMR) listed diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), dementia (a progressive mental disorder characterized by failing memory and confusion), and heart disease.R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted R1 weighed 139 pounds, had a mechanically altered diet, and had no chewing or swallowing issues. The MDS noted the resident had a significant weight loss.R1's Care Plan documented R1 had potential nutritional problems related to a history of weight loss, severe cognitive impairment, and dependence on staff for eating and drinking. He consumed a pureed diet with honey-thickened liquids, revised on 01/20/25. It instructed staff to provide R1 with a pureed diet with nectar-thick liquids and to monitor his intake; revised on 05/29/24. Staff were to give R1 a daily Mighty Shake for nutrition supplementation; initiated on 01/09/24 R1's EMR Physician Orders documented R1 was provided a pureed texture diet with honey/moderately thick drinks, related to dementia. R1 was to have a Mighty Shake two times a day. R1's Mini Nutritional Evaluation dated 09/18/25 documented R1 was malnourished. R1 had a weight of 140.2 and had a severe decrease in food intake. R1's clinical record documented a weight of 160 pounds on 03/21/25 and a weight of 140.6 pounds on 09/19/25.R1's Nutrition/Dietary Note documented the Registered Dietitian completed the Quarterly Nutritional Assessment. The score of one indicated malnutrition related to hospitalization for pneumonia (infection of the lungs) and a severe decrease in food intake with severe cognitive impairment. The note documented that staff reported the resident only eats one time a day, and staff offered a Mighty Shakes two times a day. R1's clinical record lacked documentation that R1's representative was notified of the weight loss. On 09/21/25 at 11:48 AM, R1 sat at the table with his eyes closed. Licensed Nurse (LN) H assisted him with lunch. LN H stated that when R1 closes his eyes, he is done with the meal. On 09/23/25 at 01:23 PM, Certified Nurse Aide (CNA) N stated that the CNA staff weighed the residents and recorded the weight on the clipboard. CNA N said the nurse looks at the weights and determines who has lost weight.On 09/23/25 at 01:30 PM, Administrative Nurse D stated R1 had been declining and losing weight. Administrative Nurse D stated the nurse should have notified R1's family of the change. The facility's policy Nurse Notification of Physician, Resident and Representative of Changes dated 01/09/25 documented the Nurse will notify the resident and the resident's representative of all non-immediate changes on the shift that the change occurred unless the physician directed otherwise.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility reported a census of 23 residents. The sample included 14 residents with one resident reviewed for hospitalization. Based on interview and record review, the facility failed to provide Resident (R) 1 a written notification of transfer to the resident and/or his representative as soon as practicable. Findings included:- R1's Electronic Medical Record (EMR) revealed a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively enough to meet the body's needs) schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and dementia (a progressive mental disorder characterized by failing memory and confusion).R1's EMR documented a Health Status Note dated 08/24/25 at 07:00 AM that documented R1 was barely responsive with rapid breaths. The provider was notified and ordered R1 to be sent to the hospital for evaluation.R1's EMR documented a Health Status Note dated 08/26/25 at 01:40 PM that the bed hold was sent to the guardian.R1's EMR lacked documentation of a written notification to the resident and/or his representative, which explained the reason for the transfer to the hospital.On 09/23/25 at 11:17 AM, Licensed Nurse (LN) G stated she was not aware of who provided the bed hold information and the letter in writing to the DPOA/Guardian.On 09/23/25 at 11:21 AM, Administrative Nurse D stated she provided the Ombudsman notification monthly for all the discharges and transfers out of the facility. Social Service Staff X or Administrative Staff A provided the bed hold to the family. Administrative Nurse D was unaware of the requirement to notify the resident and/or his representative in writing of the reason for transfer to the hospital and confirmed that this was not done for R1's transfer on 07/14/25.On 09/23/25 at 11:23 AM, Administrative Staff A stated that Social Service Staff X or she gave the Bed Hold to the resident's representatives. Administrative Staff A was not aware of the requirement to notify the resident and/or his representative in writing of the reason for transfer to the hospital and confirmed that this was not done for R1's transfer on 08/24/25.The facility did not provide a policy.

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Pioneer Lodge	300 W 3rd Coldwater, KS 67029

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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. The facility reported a census of 23 residents; the sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to implement interventions to prevent further falls after a fall for Resident (R) 7 and 14.Findings included:- R7's Electronic Medical Records (EMR) documented diagnoses that included anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hallucination (sensing things while awake that appear to be real, but the mind created), history of falls, and cognitive decline. R7's 07/14/25 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. The MDS documented R7 had two or more falls within the last quarter.R7's Care Plan documented R7 was at high risk for falls related to confusion, incontinence, being unaware of safety needs, vision and hearing problems, and wandering; initiated on 02/02/24. Staff were to place R7's wheelchair by her bed, and anti-roll back brakes were attached on 02/07/24. A bed alarm was placed on 09/01/24. Staff were to frequently check on R7 initiated on 12/10/24, and lower the bed to the lowest position initiated on 06/04/25. R7's Incident Note dated 08/20/25 at 02:30 PM documented the floor alarm sounded, and staff found R7 on the floor beside her bed. R7 had a dime-sized skin tear on her back. R7's Care Plan documented that the intervention was to remind R7 to use the call light, initiated on 08/20/25.On 09/22/25 at 8:52 AM, R7 lay in bed in her room. R7's wheelchair was beside her bed, and the motion sensor was facing her. On 09/23/25 at 4:23 PM, Certified Nurse Aide (CNA) N stated that when a resident fell, she got the nurse, and the nurse assessed the resident, checked vital signs, and started neurological checks. CNA N said the nurse decided on interventions and stated CNA staff were not involved in the process, but sometimes the restorative aide helped. CNA N said the nurse or Administrative Nurse D tells them what the interventions are, and they put it on the report sheet. On 09/23/25 at 4:27 PM, Licensed Nurse (LN) G stated that when a resident fell, she assessed them and started interventions. LN G said she was unsure who came up with the interventions, but assumed that Administrative Nurse D decided on the interventions and told staff. On 09/23/25 at 4:34 PM, Administrative Nurse D stated that the charge nurse was supposed to come up with the intervention at the time of the fall, and then the MDS nurse followed up on it and made sure it was in the computer, and everyone knew about it. Administrative Nurse D said she expected staff to come up with an appropriate intervention for every fall. Administrative Nurse D verified that reminding R7 to use her call light was not an appropriate intervention, as she could not retain the information. - R14's Electronic Medical Records (EMR) documented diagnoses that included bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).R14's 08/11/25 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of ten, indicating moderate cognitive impairment. The MDS documented R14 had no falls within the last quarter.R14's Care Plan last updated 04/03/25 documented R14 was at risk for falls. R14 was independent with a walker; dated 03/20/24. R14 was to wear oxygen, dated 01/15/25.R14's Incident Note dated 02/11/25 at 07:15 AM documented R14 was standing as she put in her dentures, and she fell. At the time of the fall, her oxygen saturation (percentage of oxygen in the blood) was 89 percent, and R14 was not wearing oxygen. R14's Care Plan documented no updates were made to the care plan for the 02/11/25 fall. On 09/21/25 at 11:21 AM, R14 was in the bathroom, and her walker was outside the bathroom door. R14 was short of breath and did not have her oxygen on. A staff member entered and assisted her. On 09/23/25 at 4:23 PM, Certified Nurse Aide (CNA) N stated that when a resident fell, she got the nurse, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the nurse assessed the resident, checked vital signs, and started neurological checks. CNA N said the nurse decided on interventions and stated CNA staff were not involved in the process, but sometimes the restorative aide helped. CNA N said the nurse or Administrative Nurse D tells them what the interventions are, and they put them on the report sheet. On 09/23/25 at 4:27 PM, Licensed Nurse (LN) G stated that when a resident fell, she assessed them and started interventions. LN G said she was unsure who came up with the interventions, but assumed that Administrative Nurse D decided on the interventions and told staff. On 09/23/25 at 4:34 PM, Administrative Nurse D stated that the charge nurse was supposed to come up with the intervention at the time of the fall, and then the MDS nurse followed up on it and made sure it was in the computer, and everyone knew about it. Administrative Nurse D said she expected staff to come up with an appropriate intervention for every fall.The facility's policy Fall Follow-up Protocol dated 01/09/25 documents the fall is documented on the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow-up. To determine causal factors, a Root Cause Analysis will be conducted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility reported a census of 23 residents. The sample included 14 residents. Based on observation, interview and record review, the facility failed to use adequate hand hygiene when caring for residents. Additionally, staff failed to disinfect the mechanical lift after use. Findings included:- Observation on 09/22/25 at 12:46 PM, Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) P brought the mechanical lift to the room and transferred Resident(R) 9 to the bed. R9 had been incontinent of a large soft stool. CMA R washed R9's buttocks, removed her gloves, and washed her hands, then applied new gloves and gathered more wipes out of the packet. They rolled R9 onto her back, and CNA P performed front peri care; she took her gloves off and applied new gloves without hand hygiene, then applied barrier cream. CNA P then removed her gloves and applied clean gloves again without hand hygiene. CNA P then took a new outfit out of R9's closet, and they dressed R9. Staff removed the lift from R9's room and placed it into R3's room with no sanitation completed on the lift by CMA R or CNA P. On 09/23/25 at 10:15 AM, CNA P reported that the facility does not have sanitation wipes to wipe off the mechanical lift between residents. She also reported that she would normally wash her hands after she removed her gloves before applying new gloves, but she was nervous. On 09/23/25 at 2:16 PM, Administrative Nurse D stated that she expected staff to use appropriate hand hygiene, which included hand hygiene after removing soiled gloves prior to putting on clean gloves. Administrative Nurse D stated that the reusable shared equipment, like the mechanical lifts, should be sanitized after each use.The facility's policy Hand Hygiene dated 01/09/25 documented that staff were to change gloves during resident care when moving from a contaminated site to a clean site and decontaminate their hands after removing gloves by using appropriate hand hygiene.The facility's policy Cleaning and Infection Control of Non-Critical, Reusable Resident Care Equipment dated 01/09/25 documented that all items routinely shared will be cleaned between uses and will also follow a regular schedule for cleaning and disinfection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. The facility reported a census of 23 residents; the sample included 14. Based on interview and record review the facility failed to ensure staff adhered to the principles of antibiotic stewardship through monitoring for the appropriate use of antibiotics prescribed for Resident (R) 2 to prevent antibiotic resistance and spread of multidrug resistant organisms within the facility. Findings included:- R2's Electronic Medical Record (EMR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).R2's 09/08/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The MDS recorded R2 required moderate assistance from staff to complete toileting hygiene. The MDS recorded R2 was occasionally incontinent of urine, and R2 had a urinary tract infection (UTI-an infection in any part of the urinary system) in the past 30 days.R2's 09/16/25 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented R2 required moderate assistance with toileting hygiene, and R2 was occasionally incontinent of bladder. R2 had a UTI and finished oral antibiotics on 08/16/25. R2 also had a confirmed UTI on 05/15/25. The CAA noted that a care plan would be developed to minimize risks and avoid complications related to urinary incontinence, including prevention of UTIs.R2's Care Plan documented she had a history of UTIs and was at risk for UTIs dated 08/19/25. The plan instructed staff to encourage adequate fluid intake dated 08/12/25. The plan directed staff to monitor, document, and report to the physician for any signs or symptoms of UTI: frequency, urgency, malaise, foul-smelling urine, painful urination, fever, nausea, vomiting, loss of appetite, and or behavioral changes.R2's Progress Note on 02/05/25 at 05:02 PM documented R2 complained of painful urination and upset stomach and reported she felt like she had a UTI. Staff obtained a urine sample and sent it to the lab. The physician ordered to administer Keflex (antibiotic medication) 500 milligrams (mg) twice a day for seven days.R2's Laboratory Report dated 02/07/25 at 08:00 AM, documented a culture and sensitivity (C&S) report of the susceptible (the bacteria causing an infection are likely to be effectively treated with the specific antibiotic being tested) antibiotics to administer for the UTI. Keflex was not on the list of susceptible antibiotics for the infection. The lab report documented it was sent to the provider via modem and faxed to the provider on 02/09/25.R2's Medication Administration Record (MAR) documented R2 was administered Keflex 500 mg, by mouth, two times a day from 02/05/25 through 02/12/25.R2's Progress Note on 08/11/25 at 07:14 PM, documented R2 provided a urine specimen due to complaints of UTI, low back pain, and burning with urination; the urine tested positive for leucocytes (white blood cells), blood, protein, and bilirubin (breakdown of red blood cells). Staff called the provider. R2's Progress Note on 08/11/25 at 07:20 PM, documented staff received new orders from the physician to send urine to the lab for C&S and administer Keflex 500 mg by mouth three times a day for five days.R2's Laboratory Report dated 08/14/25 at 08:00 AM, documented a C&S report of the susceptible antibiotics to administer for the UTI. Keflex was not on the list of susceptible antibiotics for the infection. The provider documented on the lab report on 08/14/25 that there were no orders, and it was noted by Licensed Nurse (LN) H 08/14/25.R2's MAR documented R2 was administered Keflex 500 mg, by mouth, 15 times from 08/11/25 through 08/16/25.During an interview/observation on 09/21/25 at 12:50 PM, R2 was seated in her recliner in her room as she watched television. R2 reported she would get UTIs often and did not know why. She reported she did require some staff assistance in the bathroom, but declined to be observed during the survey.During an interview on 09/23/25 at 10:45 AM, LN G reported that if the physician ordered an antibiotic before the C&S report was received, the nurse would update the physician on the C&S report. LN G said she expected the physician to order one of the susceptible antibiotics on the report.During an interview on 09/23/25 at 02:16 PM, Administrative Nurse D, who was also the facility's Infection Preventionist, stated she expected the physician to follow the C&S report and administer the correct antibiotic. Administrative Nurse D reported she had (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no documentation from the physician as to why he did not change the Keflex orders in February and August 2025.The facility's policy Antibiotic Stewardship dated 08/2024, documented that it is the facility's policy to implement antibiotic stewardship to promote appropriate use of antibiotics while optimizing the treatment of infections. An antibiotic review process, also known as antibiotic time-out (ATO), is conducted for all antibiotics prescribed in the facility. ATOs prompt clinicians to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 23 residents. Based on observation, interview, and record review, the facility failed to ensure the daily staff posting included the actual hours worked by the nursing staff as required. Findings included:- During an observation on 09/21/25 at 11:00 AM, the daily staff posting document lacked documentation of actual hours worked. Furthermore, it was difficult to read the titles of the staff Certified Nurse Aide (CNA), Licensed Practical Nurse (LPN), and Registered Nurse (RN) above the columns for the shifts.Review of the daily staff posting documents from 09/21/25 to 09/23/25 revealed a lack of documentation of actual hours worked.During an interview on 09/22/25 at 03:50 PM, Administrative Nurse D stated she had never documented the actual hours worked for the posted staff sheet.The facility did not provide a policy for posted nursing staff.

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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 23 residents. Based on interview and record review, the facility failed to electronically submit accurate staffing information through Payroll-Based Journaling (PBJ). Findings included:- The PBJ Staffing Data Report for Fiscal Year (FY) 2024 Quarter 3 (April 1 - June 30) documented the facility had excessively low staffing. FY 2024 Quarter 4 (July 1 - September 30) documented facility failed to have licensed nursing (LN) coverage 24 hours on the following days: 07/05/24, 07/06/24, 07/07/24. 07/10/24/ 07/11/24, 07/19/24, 07/20/24, 08/04/24, 08/08/24, 09/01/24, 09/05/24, 09/27/24, 09/28/24, and 09/29/24. FY 2025 Quarter 2 (January 1 - March 31) documented facility failed to have licensed nursing coverage 24 hours on the following days: 01/01/25, 01/02/25, 01/03/25, 01/04/25, 01/05/25, 01/18/25, 02/22/25, 03/03/25, 03/17/25, and 03/22/25.Review of the Daily Nurse Staffing Form and Payroll Data Sheets indicated the days listed above were covered with the appropriate staff, with LN coverage 24 hours each day. Additionally, no concerns with low weekend staffing were noted.During an interview on 09/22/25 at 03:43 pm, Administrative Staff A stated the PBJ report was submitted from an outside firm. Additionally, Administrative Staff A stated she expected he report to be completed accurately and realized some concerns with FY Quarter 1 and has started to see an improvement.The facility's policy Payroll Based Journal dated 08/18/25, documents this policy, which outlines the guidelines and procedures for maintaining accurate and timely records of staff employment and payroll information in this facility, in accordance with the Payroll-Based Journal (PBJ) reporting requirements. This policy aims to ensure compliance with Federal regulations and ensure the facility promotes transparency and accountability in workforce management.