STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies represent the findings of a Health Resurvey and investigation of complaint # 163530, 163622 and 165403. In addition, A Targeted Infection Control Survey/COVID-19 Focused Survey was conducted by the Kansas Department on Aging and Disability (KDADS) on 09/03/21. The facility was found to be in compliance with Centers for Medicare and Medicaid (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. This 2567 was electronically sent to the facility on 09/09/21.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1	F 584		

or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents. Based on observation and interview, the facility failed to ensure a clean and sanitary environment for the residents of the facility in five resident rooms, located in two of three resident halls.

Findings included:

- On 09/02/21 at 09:08 AM, an environmental tour of the facility had the following areas of concern:

1. A resident room had approximately two inches of loosened baseboard by the entrance to the bathroom. The perimeter around a toilet had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2	F 584		

approximate two-inch to four-inch areas that lacked floor covering. The areas had a large build-up of dark colored grime.

2. A resident room had approximately an inch of dark grime build=up in the corners around the door frames of the room and the bathroom.

3. A resident room had approximately an inch of dark grime around the edges of the baseboard.

4. A resident room had approximately eight inches of loose baseboard in the entrance of the room, with approximately a two-inch band of grime build-up on the floor. The corners of the doorframes to the room and bathroom had approximately two inches of dirt/ grime accumulation, and approximately one half inch of grime at the base of the moldings from the door to the bathroom.

5. A resident room had approximately one-inch build-up of grime around the edges of the floor at the baseboard. The bathroom lacked two triangular shaped areas of flooring that measured approximately two by two inches on the shorter sides, and these areas contained a dark grime build-up. In addition, the floor covering lacked an additional area, approximate three by three inch, and the area had a grime build-up. There was approximately a half-inch of grime build-up in front and all around the baseboard of the bathroom and approximately two inches of grime build-up behind the sink.

On 09/03/21 at 08:20 AM, Administrative Staff A stated the expectation of the facility's environment should be clean, and without grime around the edges or in the corners and the floors around the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 toilets to be intact so the floors could be cleaned and disinfected properly. A facility policy addressing maintaining floors free from grime was unavailable. The facility failed to ensure a clean and sanitary environment for the residents of the facility in five resident rooms, located in two of three resident halls.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 41 residents with 13 residents sampled, including five residents reviewed for Activities of Daily Living (ADL). Based on observation, interview and record review, the facility failed to ensure three dependent residents had appropriate assistance with ADLs, including Resident (R)18, regarding appropriate nail care and R 20 and R 40, regarding lack of personal hygiene. Findings included: - The "Physician Order Sheet" (POS), dated 08/06/21, documented Resident (R)18 had a diagnosis of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 4	F 677		

The significant change "Minimum Data Set" (MDS), dated 11/03/20, documented the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. She had no rejection of care and required extensive staff assistance of one for personal hygiene.

The "Activities of Daily Living (ADL)/Functional Rehabilitation Potential Care Area Assessment (CAA)", dated 11/03/21, documented the resident required extensive staff assistance with ADLs.

The quarterly "MDS," dated 06/23/21, documented the resident had a BIMS score of 10, indicating she had moderately impaired cognition. She had no rejection of care and required extensive staff assistance of one for personal hygiene

The care plan for ADLs, updated 08/13/21, instructed staff the nurse would do the resident's nail care.

On 09/01/21 at 08:36 AM, the resident was in the dining room for breakfast. Her fingernails were long and dirty. Her fingernails had a dried tannish substance underneath them.

On 09/02/21 at 08:43 AM, the resident was in the dining room for breakfast. Her fingernails remained long and dirty. The dried tannish substance remained underneath her fingernails.

On 09/02/21 at 12:38 PM, Licensed Nurse (LN) H stated he had never cleaned the resident's fingernails.

On 09/03/21 at 09:29 AM, Consultant staff GG

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 5	F 677		

stated, it was the expectation that staff clean resident's fingernails.

The facility policy for "Quality of Life ADLS", dated 05/2021, included: Residents who are unable to carry out ADLs will receive the necessary care and services to maintain grooming.

The facility failed to ensure appropriate nail care for this dependent resident.

- Review of Resident (R)40's "Physician Order Sheet," dated 08/06/21, revealed diagnoses included Huntington's Disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder,) major depressive disorder (major mood disorder,) and generalized anxiety disorder (excessive nervousness/tension.)

The "Quarterly Minimum Data Set" (MDS), dated 08/17/21, assessed the resident had impaired cognitive status and required extensive assistance of one staff for personal hygiene.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA,) dated 10/15/20, assessed the resident at risk for impaired ADL and required extensive assistance with personal hygiene.

The "Care Plan," reviewed 08/17/21, instructed staff the resident required assistance of one staff for personal hygiene. The resident received a shower twice a week.

The "Bath Sheet", dated 08/15/21, documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 6	F 677		

staff shaved the resident.

Observation, on 08/31/21 at 11:00 AM, revealed the resident seated in a chair in the dining area. The resident had several days' worth of facial hair. When asked if the facial hair caused itching the resident answered yes. The resident remained with facial hair on 09/01 through 09/02/21.

Interview, on 09/02/21 at 01:40 PM, with Certified Nurse Aide (CNA) NN, revealed staff should shave the resident on bath days (Monday and Thursday evenings.) If staff do not shave him on those days, then the best time to shave him is after a nap when he is more cooperative.

Interview, on 09/02/21 at 04:00 PM with CNA N, revealed she usually shaved the resident when she provided a bath to him, but she was off the previous week.

Interview, on 09/03/21 at 11:28 AM, with Consulting Nurse GG, revealed she would expect staff to provide shaving to residents per their preferences, usually on bath days.

The facility policy "Quality of Life Activities of Daily Living," reviewed 05/2021, instructed staff for residents whom are unable to carry out ADL, receive the necessary care and services to maintain good nutrition, grooming and personal and oral hygiene.

The facility failed to provide shaving opportunities for this resident who required staff assistance to maintain personal hygiene in a manner as a normal person would expect.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7	F 677		

- Review of Resident (R)20's "Physician Order Sheet," dated 08/06/21, revealed diagnoses included hemiplegia (paralysis of one side of the body,) dementia (progressive mental disorder characterized by failing memory, confusion), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

The "Annual Minimum Data Set" (MDS), dated 11/14/20, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13 (Normal cognition score 13-15.) The resident had verbal behaviors and rejection of care one to three days of the seven day look back period. The resident required extensive assistance of two staff for bed mobility, transfers, toileting and personal hygiene. The resident had no impairment in range of motion in the upper or lower extremities.

The "ADL (Activity of Daily Living) Functional/ Rehabilitation Potential Care Area Assessment" (CAA), dated 11/14/20, assessed the resident was at risk for impaired ADL function related to history of stroke, hemiplegia and right below the knee amputation. The resident required limited to extensive assistance of one to two staff for ADL.

The "Care Plan," reviewed 05/25/21, instructed staff the resident was at increased risk for impaired skin integrity related to impaired mobility. Staff were to complete a weekly skin assessment and provide a skin check during showers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 8	F 677		

Observation, on 08/31/21 at 10:30 AM, revealed the resident in his wheelchair in his room. The resident's face contained several days' worth of facial hair. Observation on 09/01/21 revealed continued facial hair until 09/02/21 at which time the resident was shaven.

Interview, on 09/01/21 at 09:23 AM, with Certified Nurse Aide (CNA) O revealed the resident required assistance for ADL's and usually CNA N shaved him on evening shift.

Interview, on 09/01/21 at 03:56 PM, with CNA PP, revealed the resident could get combative at times.

Interview, on 09/02/21 at 01:40 PM, with Certified Nurse Aide (CNA) NN, revealed staff should shave the resident on bath days. If staff do not shave him on those days, then the best time to shave him is after a nap when he is more cooperative.

Interview, on 09/02/21 at 04:00 PM with CNA N, revealed she usually shaved the resident on bath days or when they needed to be shaved.

Interview, on 09/03/21 at 11:28 AM, with Consulting Nurse GG, revealed she would expect staff to provide shaving to residents per their preferences, usually on bath days.

The facility policy "Quality of Life Activities of Daily Living," reviewed 05/2021, instructed staff for residents whom are unable to carry out ADL, receive the necessary care and services to maintain good nutrition, grooming and personal and oral hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 9 The facility failed to provide shaving opportunities for this resident who required staff assistance to maintain personal hygiene in a manner as a normal person would expect.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility reported a census of 41 residents, with 13 residents sampled, including seven residents sampled for activities. Based on observation, interview and record review, the facility failed to provide activities for three Residents (R) 22, R11, and R28 to enhance their lives through activities of their choice. Findings included: - Review of Resident (R) 22's "Physician Order Sheet," dated 07/16/21, revealed diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body). The "Annual Minimum Data Set" (MDS), dated	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 10	F 679		

12/30/20, assessed the resident with moderately impaired cognitive status, the resident was unable to speak, and rarely /never understood. The resident required total dependence for activities of daily living. The resident's preferences included listening to music, pets and animals.

The "Cognitive Loss Care Area Assessment" (CAA), dated 12/30/20, assessed the resident was at risk for cognitive loss.

The "Communication" CAA, dated 12/30/20, assessed the resident was at risk for communication deficits due to aphasia (condition with disordered or absent language function)'

The "Activities" CAA, dated 12/30/20, assessed the resident preferred not to participate in facility activities.

The "Care Plan," reviewed 06/16/21, instructed staff the resident occasionally enjoyed watching "Animal Planet "and "Scy Fy" on TV. The resident enjoyed listening to meditation music and listening to his portable waterfall running. The resident enjoyed being read to and manicures.

Observation on 08/31/21 and on all days of the survey revealed the television on the "Animal Planet" station, continuously. The resident appeared to be watching the television intermittently. The resident did not have a portable waterfall or meditation music.

Interview, on 09/01/21 at 01:00 PM with Certified Nurse Aide (CNA) O, revealed the resident usually stays in bed and watched TV. CNA O

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 11	F 679		

stated the resident liked animals.

Interview, on 09/01/21 at 01:10 PM, with Activity Staff Z, revealed she provided one on one reading and talking and opened the window, so he could hear the rain.

Interview, on 09/01/21 at 03:56 PM, with CNA PP, revealed the resident does not like to get up out of bed and usually watched the "Animal Planet" station. CNA PP did not know of any other activity the resident enjoyed.

Interview, on 09/02/21 at 09:35 AM, with Licensed Nurse (LN) H, revealed he used to have a device that played birds and water flowing, but he did not know what happened to the device.

Interview, on 09/03/21 at 11:48 AM, with Consulting Nurse GG, revealed the Activities Staff did one on one with the resident. The previous Activities Staff had a "White Noise" device she used for the resident's enjoyment, but she was no longer at the facility.

The facility "Activities and Social Events," reviewed 05/21, instructed staff the resident should be given an opportunity to choose when, where and how he will participate in activities and develop a plan of care based on resident's interests and assessments.

The facility failed to provide this dependent resident with activities other than constant television, to enhance the resident's enjoyment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 12	F 679		

- The "Physician Order Sheet" (POS), dated 08/06/21, documented Resident (R)11 had diagnoses, which included: bipolar (major mental illness that caused people to have episodes of severe high and low moods) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The significant change "Minimum Data Set" (MDS), dated 03/20/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. It was somewhat important for her to listen to music she likes and to do her favorite activities. She required total assistance of one staff for locomotion on the unit.

The "Activities Care Area Assessment" (CAA), dated 03/20/21, did not trigger.

The quarterly "MDS," dated 06/20/21, documented the resident's BIMS score was 11, indicating moderate cognitive impairment. She required total assistance of one staff for locomotion on the unit.

The Activities care plan, updated 06/07/21, instructed staff the resident would occasionally attend group activities. Staff were to encourage the resident to attend activities.

Review of the resident's electronic medical record (EMR), under the "Assessment" tab, revealed the resident enjoyed music, movies and sports.

Review of the resident's EMR, under the "Tasks" tab, from 08/07/21 through 09/02/21, revealed the resident had no activities provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 13	F 679		

On 09/01/21 at 09:18 AM, the resident sat in the commons area in the recliner. The resident's eyes were opened and she was alert. The TV was playing a child's cartoon. The resident was not watching the cartoon and did reported did not like cartoons.

On 09/01/21 at 10:50 AM, the resident remained in the commons area in a recliner. There was a small group musical activity taking place in one of the dining areas. Staff had not invited the resident to attend the music activity.

On 09/01/21 at 10:50 AM, the resident stated she had not been invited to attend the music activity and would have liked to have been invited.

On 09/01/21 at 09:11 AM, Certified Nurse Aide (CNA) M stated the resident did not participate in activities.

On 09/01/21 at 01:10 PM, Activity staff Z stated, residents who are not mobile enough or who need a lot of assistance do not come to activities. Staff Z stated that the resident liked music activities.

On 09/02/21 at 12:38 PM, Licensed Nurse (LN) H stated, he had not seen the resident participating in any type of activity.

09/03/21 at 09:29 AM, Consultant staff GG, stated she would expect the residents to have 1:1 activity or attend music activities if that was something that the resident enjoyed doing.

The facility policy for "Activities and Social Events", effective 05/2021, included: The staff will evaluate a resident's physical and mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 14	F 679		

capacity to participate in various levels of activities.

The facility failed to provide individualized appropriate activities for this dependent resident.

- The "Physician Order Sheet" (POS), dated 08/06/21, documented Resident (R)28 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The annual "Minimum Data Set" (MDS), dated 10/28/20, documented the staff assessment for cognition revealed the resident had moderate cognitive impairment. The staff assessment for activity preferences revealed the resident enjoyed listening to music and spending time outdoors. She required total assistance of one staff for locomotion on the unit.

The "Activities Care Area Assessment" (CAA), dated 10/28/20, documented the resident was at risk for not participating in activities due to inattention related to dementia. Staff were to encourage the resident to participate in activities in which she enjoyed.

The quarterly "MDS," dated 07/26/21, documented the staff assessment for cognition revealed the resident was moderate cognitive impairment. She required total assistance of one staff for locomotion on the unit.

The activities care plan, updated 05/11/21, instructed staff to encourage the resident to attend activities she enjoyed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 15	F 679		

Review of the resident's electronic medical record (EMR), revealed a "Recreation (Activities): Admission/Annual Assessment", dated 10/26/20, which was left blank.

Review of the resident's EMR, under the "Tasks" tab, from 08/07/21 through 09/02/21, revealed the resident participated in no activities.

On 09/01/21 at 10:50 AM, a music activity took place in one of the dining areas. Staff did not invite the resident to attend.

On 09/01/21 at 02:45 PM, an activity of making pudding in a jar took place in the activity room. Staff did not invite the resident to attend.

On 09/01/21 at 08:39 AM, Certified Nurse Aide (CNA) O stated, she does not inform the resident of activities occurring in the facility.

On 09/01/21 at 01:10 PM, Activity staff Z stated, residents who are not mobile enough or who need a lot of assistance do not come to activities. Staff Z stated that the resident liked music activities.

On 09/03/21 at 09:29 AM, Consultant staff GG, stated she would expect the residents to have 1:1 activity or attend music activities if that was something that they enjoyed doing.

The facility policy for "Activities and Social Events", effective 05/2021, included: The staff will evaluate a resident's physical and mental capacity to participate in various levels of activities.

The facility failed to provide individualized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 16 appropriate activities for this dependent resident.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 41 residents with 13 selected for review which included two residents reviewed for skin issues. Based on observation, interview and record review, the facility failed to implement measures for skin protection as advised by hospice for one resident (R)19 and failed to investigate and monitor the bruising and skin tear for R20. Findings included: - Review of R19's "Physician Order Sheet," dated 08/18/21, revealed diagnoses included sarcopenia (loss of muscle mass), anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues,) cachexia (a state of ill health involving weight loss and loss of muscle mass,) psoriatic (chronic skin disorder characterized by red patches covered by thick, dry silvery adherent scales) arthropathy (joint disease), psychosis (any major mental disorder characterized by a gross impairment in reality testing,) and major depressive disorder	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

(major mood disorder).

The "Significant Change Minimum Data Set" (MDS), dated 06/23/21, assessed the resident with normal cognitive status, required extensive assistance of two person for bed mobility, transfer, dressing, and toilet use. The resident required extensive assistance of one person for personal hygiene. The resident received hospice services and had one unhealed pressure ulcer.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 06/23/23, assessed the resident at risk for impaired skin integrity related to incontinence and impaired mobility.

The care plan, revised 07/02/21, instructed staff to cleanse the buttock ulcer with wound cleanser, dab dry, and apply Polyox (a type of medicated powder to heal wounds) to the wound and cover with a foam dressing. The care plan instructed staff the resident received hospice services.

The facility lacked a care plan from the hospice agency.

The "Nursing Skin Wound Note," dated 08/09/21, documented the buttock ulcer as closed.

The "Hospice Nurse Note," dated 08/10/21 in the hospice notebook, revealed an evaluation that the resident had two- dime sized areas on his buttocks that looked like shearing (wound caused by friction) and staff was to apply Calmoseptine (a medicated cream that forms a moisture barrier to protect the skin from irritants and moisture) after each brief change.

The "Treatment Administration Record" (TAR) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

August 2021, documented the treatment with Plyox discontinued on 08/12/2021, as the wound healed. The TAR lacked documentation of the hospice recommendation for Calmoseptine use.

Observation, on 09/01/21 at 01:30 PM, revealed the resident positioned in his recliner. Licensed Nurse (LN) G and Certified Nurse Aide (CNA) OO turned the resident in his recliner. The resident's incontinence brief saturated with urine, and the resident's buttocks contained three shallow open areas with sanguineous (bloody) drainage.

Observation, on 09/01/21 at 02:30 PM, after the resident received a whirlpool bath, LN G measured the open areas as 0.8 by 0.8 centimeters (cm) on the right buttock, left inner buttocks 2.8 by 0.5cm and 1.3 by 1.5cm.

Interview, on 09/01/21 at 02:30 PM, with LN G revealed the resident's pressure ulcers had healed but did not know what could be used for these areas of shearing. LN G stated usually the hospice nurse gave a verbal report after the visit with the resident. LN G stated sometimes the charge nurse read the hospice notes but did not recall the note that indicated the recommendation for Calmoseptine to the areas of shearing on the resident's buttocks.

Interview on 09/01/21 at 03:56 PM, with CNA PP, revealed the resident was incontinent of urine and used his call light to alert staff when he was wet, and staff provided incontinence care. CNA PP stated staff applied lotion to his arms and legs, but the resident did not like the Calmoseptine on his buttocks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19	F 684		

Interview, on 09/03/21 at 10:30 AM with Consulting Nurse GG, revealed staff should read the hospice notes and follow through with recommendations.

The facility policy "Hospice Interpretation and Implementation," revised 06/2021, instructed staff to establish a communication mechanism with hospice provider for clinical changes in the care of the resident.

The facility failed to coordinate hospice care recommendations for use of calmoseptine ointment to provide a protective barrier for this resident skin to prevent irritation and further damage.

- Review of Resident (R)20's "Physician Order Sheet," dated 08/06/21, revealed diagnoses included hemiplegia (paralysis of one side of the body,) dementia (progressive mental disorder characterized by failing memory, confusion), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

The "Annual Minimum Data Set" (MDS), dated 11/14/20, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13 (Normal cognition score 13-15.) The resident had verbal behaviors and rejection of care one to three days of the seven day look back period. The resident required extensive assistance of two staff for bed mobility, transfers, toileting and personal hygiene. The resident had no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20	F 684		

impairment in range of motion in the upper or lower extremities.

The "ADL (Activity of Daily Living) Functional/ Rehabilitation Potential Care Area Assessment" (CAA), assessed the resident was at risk for impaired ADL function related to history of stroke, hemiplegia and right below the knee amputation. The resident required limited to extensive assistance of one to two staff for ADL.

The "Care Plan," reviewed 05/25/21, instructed staff the resident was at increased risk for impaired skin integrity related to impaired mobility. Staff were to complete a weekly skin assessment and provide a skin check during showers. Staff was to provide education to the resident and caregivers as to the cause of skin breakdown which included transfer, positioning and taking care during ambulation.

The electronic medical record lacked documentation of the right arm injury.

Observation, on 08/31/21 at 10:30 AM, revealed the resident in his wheelchair in his room. The resident's right forearm arm contained an area wrapped in undated Coban (an elastic type of wrap).

Interview, on 09/01/21 at 09:23 AM, with Certified Nurse Aide (CNA) P, revealed the resident required assistance for ADL's and required the sit to stand lift mechanical lift for transfers. CNA P stated the resident had fragile skin, and probably had a skin tear under the dressing on his right forearm.

Observation on 09/01/21 at 09:35 AM, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21 Licensed Nurse (LN) G, removed the undated dressing from the resident's right forearm and measured a 13 by 12 centimeter (cm) irregularly shaped purple bruise with a skin tear measuring 1.6 by 0.2 cm. LN cleansed the area with skin cleanser, then place a foam dressing over the skin tear. LN G stated she did know the resident had the bruise or skin tear, but the resident did have fragile skin and frequently had bruising and skin tears. LNG stated staff should monitor the bruise and skin tear for resolution on the treatment administration record. Interview, on 09/01/21 at 03:56 PM, with CNA PP, revealed the resident could get combative at times. CNA PP stated she did not know what the dressing on his right arm was for. Interview, on 09/03/21 with Consulting Nurse GG, revealed she would expect staff to document injuries such as the 13 by 12 cm bruise with a skin tear, determine the root cause of the injury, provide treatment and monitor for resolution. The facility policy "Skin Tears Abrasions and Minor Breaks," reviewed 05/21, instructed staff to complete a "Report of Incident /Accident" form and document measurements, appearance shape of wound and treatment provided. The facility failed to investigate and monitor this resident's 13 by 12 cm bruise with skin tear and to determine interventions for further prevention.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 22	F 690		

resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents with 13 residents sampled, including one resident reviewed for urinary incontinence (involuntary passage of urine) and Indwelling urinary catheter (insertion of a catheter into the bladder to drain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 23	F 690		

the urine into a collection bag). Based on interview, record review, and observation, the facility failed to care for the catheter in a clean manner to prevent infections for the one Resident (R)7 sampled.

Findings included:

- The "Physician Order Sheet" (POS), dated 07/16/21, documented Resident (R)7 had a diagnosis of urinary retention (the inability to empty the bladder).

The annual "Minimum Data Set" (MDS), dated 12/23/20, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She required total assistance of two staff for toilet use and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA)," dated 12/23/20, documented the resident had an indwelling urinary catheter.

The quarterly "MDS," dated 06/23/21, documented the resident had a BIMS score of 15, indicating intact cognition. She required total assistance of two staff for toilet use and had an indwelling urinary catheter.

The care plan for toileting, dated 08/03/21, instructed staff the resident had an indwelling urinary catheter. Staff were to position the catheter bag and tubing below the level of the resident's bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 24	F 690		

On 09/02/21 at 12:50 PM, Certified Nurse Aide (CNA) M entered the resident's room to perform catheter care. CNA M opened several packets of alcohol wipes and laid them directly on the floor next to the resident's bed. CNA M unhooked the spigot from the catheter collection bag and drained 800 cubic centimetres (ccs) of dark urine into the graduate (a container used to measure liquids such as urine). She then picked up an alcohol pad, resting directly on the resident's floor, and wiped the spigot of the catheter collection bag with the soiled alcohol swab. CNA M then emptied the urine into the toilet and drained out 300 ccs of dark urine from the collection bag, emptying the catheter collection bag completely.

On 09/02/21 at 12:50 PM, CNA M stated she had picked up the alcohol swab, which rested directly on the resident's dirty floor, and used it to clean the spigot of the catheter collection bag. CNA M stated she should not have used the soiled alcohol swab.

On 09/02/21 at 01:38 PM, Licensed Nurse H stated, staff should use clean alcohol swabs when cleaning the catheter collection bag.

On 09/03/21 at 09:29 AM, Consultant staff GG stated, she would expect staff to use clean alcohol swabs when performing catheter care.

A facility policy for cleaning and care of a urinary catheter was not made available.

The facility failed to care for the indwelling urinary catheter for this dependent resident in a clean manner in order to prevent infections.