STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 03/05/2020.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/05/2020

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
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 657	Continued From page 1	F 657		

The facility reported a census of 38 residents. The sample of 13 residents included in the sample. Based on observation, interview, and record review, the facility failed to failed to review and revise the care plan for one sampled resident, Resident (R) 33 to direct staff to provide fluids during cares to ensure adequate hydration for this dependant resident.

Findings included:

- The signed "Physician Order Sheet" (POS), for R 33, dated 12/30/2019, documented the resident had the following diagnoses: obstructive hydrocephalus (a pathologic condition characterized by an abnormal accumulation of cerebrospinal fluid), cerebral palsy (progressive disorder or movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), epilepsy (brain disorder characterized by repeated seizures), and unspecified intellectual (the power and ability of the individual for knowing and understanding) disabilities.

The Significant Change "Minimum Data Set" (MDS), dated 07/26/2019, documented staff were unable to obtain a Brief Interview for Mental Status (BIMS) score as the resident was rarely/never understood, and had impaired cognition. The resident
required extensive assistance of staff with eating and drinking.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 08/06/2019, documented the resident had a severe cognitive impairment and diagnoses of hydrocephalus and cerebral palsy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 657	Continued From page 2	F 657		

The "Activity of Daily Living Functional/Rehabilitation CAA" did not trigger.

The "Dehydration/Fluid Maintenance CAA," dated 08/07/2019, documented the resident had severe cognitive and functional impairment and was totally dependent on staff for all fluid intake. The resident had poor intake by mouth and the primary source of nutritional and fluid intake was her g-tube (gastronomy tube - a surgical creation of an artificial opening into the stomach through the abdominal wall). She was encouraged to eat/drink at meals as tolerated.

The "Feeding Tube CAA," dated 08/07/2019, documented the resident had a severe cognitive impairment with diagnoses of cerebral palsy, hydrocephalus, epilepsy, and dysphasia. She had a g-tube long-term and received routine bolus feedings with water flushes before and after bolus and medication administration. Staff were to offer her a mechanical soft diet with ground meats and thin liquids as tolerated. She liked Pepsi and chocolate milk.

The "Comprehensive Care Plan," dated 10/29/2019, documented the resident had a restricted diet with oral intake. She often got angry when receiving cares. The care plan stated the resident needed help with all personal cares and talking to her during cares was the best approach. The interventions directed staff to be playful in approach. The care plan further directed staff to use simple and direct choices, make sure her diet was puree with nectar liquids, she enjoyed Pepsi and chocolate milk that she drank with a straw. Nursing staff were to provide a 60 milliliter (ml) water flush before and after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 657	Continued From page 3	F 657		

bolus feedings and medications. The plan of care failed to direct staff to provide fluids during direct resident cares.

The "Registered Dietitian Assessment," dated 08/09/2019, documented the resident received Fibersource, 1 can, four times a day, which was the primary source of nutrition. The resident consumed a mechanical soft diet but eats small amounts of one to two meals daily. The resident required total assistance with food and beverage.

The "Dietary Profile", dated 01/27/2020, documented the resident received a regular diet, and g- tube, Fibersource (supplement), 1 can four times daily. The resident regular diet was of puree texture, fluid nectar thick, no restrictions with small portions. The resident liked Pepsi, chocolate milk, and required a straw.

The registered dietitian notes, dated between 12/01/2019 and 03/04/2020, documented the resident received approximately 768 ml of water with her feedings.

The Electronic Medical Record lacked a "Dehydration Risk Assessment."

Observation, on 02/26/20 at 1:39 PM, revealed the resident had dry cracked lips and dry skin on her arms.

Observation, on 02/27/2020 at 8:11 AM, revealed the resident lying in bed, awake, listening to music, her lips were dry and cracked with peeling skin and an unknown white substance in the corners of her lips and on her teeth.

On 02/27/2020 at 8:17 AM, Administrative Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 657	Continued From page 4	F 657		

E reported she agreed the resident's lips were dry and cracked with peeling skin and an unknown thick white substance on her teeth. Nurse E further confirmed the resident's lips and tongue appeared dry.

Observation, on 02/27/2020 at 8:22 AM, revealed Certified Nurse Aide (CNA) M and CNA O went into the room to provide incontinence care. Following cares, staff swabbed her mouth with mouthwash and a toothette and applied lip balm. A water pitcher was at bedside, however staff failed to offer the resident a drink of water.

Observation, on 02/27/2020 at 3:24 PM, CNA N and CNA O, went into the resident's room to provide incontinence care. Following cares, staff offered the resident a drink of water which she took without hesitation.

Observation, on 03/02/2020 at 10:26 AM, revealed License Nurse G performed a skin turgor test on the back of the resident's hand, the skin tented and then returned slowly. The staff attempted to try other areas and the resident asked her to quit.

Observation, on 03/03/2020 at 7:55 AM, revealed CNA M and CNA O take the resident to her room for incontinence care. Staff performed oral care with a toothette and mouthwash but failed to offer the resident a drink of water after cares. A Styrofoam cup of water sat at the bedside.

The policy titled, "Hydration Monitoring Protocol," dated 2016, directed staff that residents at risk for dehydration will be identified using the Dehydration Risk Assessment. The resident's fluid needs shall be determined according to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 657	Continued From page 5 Registered Dietitian's recommendations. Fluids consumed at meals will be documented in addition to meal intake for at risk residents on designated form or entered into the appropriate flow sheet within the electronic medical record. Dietary notes shall reflect factors that put the resident at risk of dehydration, and what is being done to reduce the risk factors. The residents at risk for dehydration should have the problem, goals, and interventions documented into the care plan. The facility failed to review and revise this dependent resident's hydration care plan to direct staff in providing fluids during cares to ensure she received adequate fluids.	F 657		
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 38 residents. The sample of 13 residents, included one resident reviewed for oral hygiene. Based on observation, interview, and record review, the facility failed to consistently provide Resident (R) 33 oral care resulting in a thick white substance on her teeth and in the corners of her lips. Findings included: - The signed "Physician Order Sheet" (POS), for R 33, dated 12/30/2019, documented the resident had the following diagnoses: obstructive	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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		

hydrocephalus (a pathologic condition characterized by an abnormal accumulation of cerebrospinal fluid), cerebral palsy (progressive disorder or movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), epilepsy (brain disorder characterized by repeated seizures), and unspecified intellectual (the power and ability of the individual for knowing and understanding) disabilities.

The Significant Change "Minimum Data Set" (MDS), dated 07/26/2019, documented staff were unable to obtain a Brief Interview for Mental Status (BIMS) score as the resident was rarely/never understood, and had impaired cognition. The resident required total assistance of staff with personal hygiene.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 08/06/2019, documented the resident had a severe cognitive impairment and diagnoses of hydrocephalus and cerebral palsy.

The "Activity of Daily Living (ADL) Functional/Rehabilitation CAA," did not trigger.

The "Comprehensive Care Plan," dated 10/29/2019, documented the resident needed assistance for grooming and could not do things for herself. She often got angry when receiving cares and may try to bite the toothbrush or wash cloth. The resident needed help with all personal cares and talking to her during cares was the best approach. The interventions directed staff to be playful in approach, but to get tasks completed quickly, say Momma and Daddy liked her to be clean, use a children's toothbrush, toothpaste and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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		

mouth rinse, so it can be swallowed. Staff are to use a toothbrush or toothette for oral care upon rising and at hours of sleep.

The Electronic Medical Record (EMR) evidenced the resident received ADL assistance daily two times, which included oral hygiene and showers as scheduled.

Observation, on 02/27/2020 at 8:11 AM, revealed the resident lying in bed, awake, listening to music, her lips were dry and cracked with peeling skin and an unknown thick white substance in the corners of her lips and on her teeth.

On 02/27/2020 at 8:17 AM, Administrative Nurse E reported she agreed the resident's lips were dry and cracked with peeling skin and an unknown thick white substance on her teeth.

On 02/27/2020 at 8:25 AM, Certified Nurse Aide (CNA) M reported the resident gets up each morning around 6:00 AM and staff lie her back down at 8:00 AM. Staff reported they do oral care in the mornings and usually swab her mouth every two hours when we do cares. Staff M further stated her lips get dry fast and her lips are always that way, her lips were cracked and dry.

On 02/27/2020 at 3:30 PM, CNA N reported, the resident does not want her mouth swabbed when we do cares.

On 03/03/2020 at 7:55 AM, CNA M reported, they get the resident up and they do oral care before breakfast. She does not like oral care, but at times was cooperative.

On 03/02/2020 at 10:16 AM, License Nurse G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 reported, the resident's teeth are hard to clean. The resident does breathe through her mouth so it needs to be done daily. The care plan states to do oral care UR (upon rising) and HS (hours of sleep), but not sure what UR means. Nurse D further stated due to the resident being a mouth breather maybe we need to update the care plan to have oral care after each meal. On 03/04/2020 at 1:10 PM, Administrative Staff A reported the facility does not have a policy at this time for oral care. The facility lacked a policy for oral hygiene. The facility failed to provide adequate assistance to this dependent resident with her oral hygiene needs.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 692	Continued From page 9	F 692		

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. The sample of 13 residents included one resident reviewed for hydration. Based on observation, interview, and record review, the facility failed to consistently provide Resident (R) 33 with fluids to drink when providing cares and meal assistance to ensure adequate hydration.

Findings included:

- The signed "Physician Order Sheet" (POS), for R 33, dated 12/30/2019, documented the resident had the following diagnoses: obstructive hydrocephalus (a pathologic condition characterized by an abnormal accumulation of cerebrospinal fluid), cerebral palsy (progressive disorder or movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), epilepsy (brain disorder characterized by repeated seizures), and unspecified intellectual (the power and ability of the individual for knowing and understanding) disabilities.

The Significant Change "Minimum Data Set" (MDS), dated 07/26/2019, documented staff were unable to obtain a Brief Interview for Mental Status (BIMS) score as the resident was rarely/never understood, and had impaired cognition. The resident required extensive assistance of staff with eating and drinking.

The "Cognitive Loss/Dementia Care Area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 692	Continued From page 10	F 692		

Assessment" (CAA), dated 08/06/2019, documented the resident had a severe cognitive impairment and diagnoses of hydrocephalus and cerebral palsy.

The "Activity of Daily Living Functional/Rehabilitation CAA" did not trigger.

The "Dehydration/Fluid Maintenance CAA," dated 08/07/2019, documented the resident had severe cognitive and functional impairment and was totally dependent on staff for all fluid intake. The resident had poor intake by mouth and the primary source of nutritional and fluid intake was her g-tube (gastronomy tube - a surgical creation of an artificial opening into the stomach through the abdominal wall). She was encouraged to eat/drink at meals as tolerated.

The "Feeding Tube CAA," dated 08/07/2019, documented the resident had a severe cognitive impairment with diagnoses of cerebral palsy, hydrocephalus, epilepsy, and dysphasia. She had a g-tube long-term and received routine bolus feedings with water flushes before and after bolus and medication administration. Staff were to offer her a mechanical soft diet with ground meats and thin liquids as tolerated. She liked Pepsi and chocolate milk.

The "Comprehensive Care Plan," dated 10/29/2019, documented the resident had a restricted diet with oral intake. She often got angry when receiving cares. The care plan stated the resident needed help with all personal cares and talking to her during cares was the best approach. The interventions directed staff to be playful in approach. The care plan further directed staff to use simple and direct choices,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 692	Continued From page 11	F 692		

make sure her diet was puree with nectar liquids, she enjoyed Pepsi and chocolate milk that she drank with a straw. Nursing staff were to provide a 60 milliliter (ml) water flush before and after bolus feedings and medications.

The "Registered Dietitian Assessment," dated 08/09/2019, documented the resident received Fibersource, 1 can, four times a day, which was the primary source of nutrition. The resident consumed a mechanical soft diet but eats small amounts of one to two meals daily. The resident required total assistance with food and beverage.

The "POS," dated and signed 12/30/2019, documented the following orders:

Regular diet, mechanical soft texture, nectar consistency dysphasia oral phase, start date of 01/15/2020.

Fibersource, four times daily, hold if residual was greater than 30 ml to be given at 5:00 AM (by the night nurse) 2:00 PM, 7:00 PM and 12:00 AM, four times daily, abnormal weight loss, start date of 10/21/19.

The "POS" indicated the resident received medications one time a day.

The Electronic Medical Record (EMR) lacked documentation of the amount of liquids the resident received other than 60 ml flushes with bolus feedings and medications.

The EMR indicated the resident received medications one time a day and bolus feedings four times a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 692	Continued From page 12	F 692		

The "Dietary Profile," dated 01/27/2020, documented the resident received a regular diet, and g- tube, Fibersource (supplement), 1 can four times daily. The resident regular diet was of puree texture, fluid nectar thick, no restrictions with small portions. The resident liked Pepsi, chocolate milk, and required a straw.

The EMR lacked a "Dehydration Risk Assessment."

Observation, on 02/26/20 at 1:39 PM, revealed the resident had dry cracked lips and dry skin on her arms.

Observation, on 02/27/2020 at 8:11 AM, revealed the resident lying in bed, awake, listening to music, her lips were dry and cracked with peeling skin and an unknown white substance in the corners of her lips and on her teeth.

On 02/27/2020 at 8:17 AM, Administrative Nurse E reported she agreed the resident's lips were dry and cracked with peeling skin and an unknown thick white substance on her teeth. Nurse E further confirmed the resident's lips and tongue appeared dry.

Observation, on 02/27/2020 at 8:22 AM, revealed Certified Nurse Aide (CNA) M and CNA O went into the room to provide incontinence care. Following cares, staff swabbed her mouth with mouthwash and a toothette and applied lip balm. A water pitcher was at bedside, however staff failed to offer the resident a drink of water.

Observation, on 02/27/2020 at 8:25 AM, CNA M reported the resident gets up each morning around 6:00 AM and staff lie her back down at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 692	Continued From page 13	F 692		

8:00 AM. Staff M further stated her lips get dry fast and her lips are always that way, her lips are cracked and dry.

Observation, on 02/27/2020 at 3:24 PM, CNA N and CNA O, went into the resident's room to provide incontinence care. Following cares, staff offered the resident a drink of water which she took without hesitation.

Observation, on 03/02/2020 at 10:26 AM, revealed License Nurse G performed a skin turgor test on the back of the resident's hand, the skin tented and then returned slowly. The staff attempted to try other areas and the resident asked her to quit.

Observation, on 03/02/2020 at 12:00 PM, revealed the resident being assisted with her meal. She had chocolate milk and Pepsi to drink. She drank most of the 360 ml of milk and only a small amount of 240 ml of Pepsi.

Observation, on 03/03/2020 at 7:55 AM, revealed CNA M and CNA O take the resident to her room for incontinence care. Staff performed oral care with a toothette and mouthwash but failed to offer the resident a drink of water after cares. A Styrofoam cup of water sat at the bedside.

On 02/27/2020 at 3:30 PM, CNA N reported, the resident had a g-tube, but she also takes things by mouth, she can eat and drink. Staff should offer her drinks when doing cares.

On 03/03/2020 at 7:55 AM, CNA M reported, they get the resident up and they do oral care before breakfast. She does not like oral care or water, but at times was cooperative. The resident does

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 692	Continued From page 14	F 692		

not drink water very well, she seldom drinks water.

On 03/03/2020 at 11:39 AM, CNA P reported, she assisted the resident with her noon meal. The resident had only a small glass of Pepsi and only drank half of the Pepsi. CNA P further reported the resident does not get water or chocolate milk at lunch time.

On 03/02/2020 at 10:16 AM, License Nurse G reported, the resident had a g-tube but also took food and drink by mouth. The resident liked Pepsi at meals, she has a water cup at bedside, so besides her feeding, she would expect staff to offer water to the resident during cares. Nurse G further stated she had noticed her lips were chapped often.

The policy titled, "Hydration Monitoring Protocol," dated 2016, directed staff that residents at risk for dehydration will be identified using the Dehydration Risk Assessment. The resident's fluid needs shall be determined according to the Registered Dietitian's recommendations. Fluids consumed at meals will be documented in addition to meal intake for at risk residents on designated form or entered into the appropriate flow sheet within the electronic medical record. Dietary notes shall reflect factors that put the resident at risk of dehydration, and what is being done to reduce the risk factors. The residents at risk for dehydration should have the problem, goals, and interventions documented into the care plan.

The facility failed. consistently provide Resident (R) 33 with fluids to drink when providing cares and during meal assistance to ensure adequate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 692	Continued From page 15 hydration.	F 692		