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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically emailed to the facility on 04/24/23.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		

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.

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desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 45 residents with 12 included in the sample. Based on observation, interview, and record review the facility failed to develop a comprehensive care plan for one Resident (R) 10 of the 12 sampled residents, related to comfort care status.

Findings included:

- Resident (R) 10's signed physician orders dated 04/06/23, included the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), chronic kidney disease (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), hypertension (elevated blood pressure), history of alcohol dependence, major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and

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irrational fear).

The Quarterly Minimum Data Set (MDS) dated 12/13/22 revealed the resident required supervision with daily cares including personal hygiene. No dental concerns noted. The resident received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and antibiotic daily through the seven-day look-back observation period.

Review of the annual MDS dated 03/02/23 revealed intact cognition. The resident was independent for activities of daily living (ADL's). No dental issues and received the same medications with no changes made.

Review of the "Activities of daily living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 03/02/23, revealed the resident was alert and orientated with intact cognition. The resident was able to make her own decisions and preferred comfort care measures only as she did not want any labs, X-rays or interventions done. The resident was independent in ADL's and was ambulatory with her rolling walker and had a steady gait.

The "Care Plan" dated 11/23/21, revealed the resident had a self-care deficit.

The care plan lacked staff guidance in reference to her comfort care status and her preferences of what care she did not want.

On 04/17/23 at 11:35 AM, the resident reported

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F 656	Continued From page 3 she could take care of herself and did not want all that doctor stuff. She was okay how she was. On 04/18/23 at 01:45 PM, Certified Medication Aide D reported the resident was very independent. She absolutely refused staff to clean her teeth. The last time the nurse tried helping her clean her dentures the resident tried to bite her. She is on comfort care and refuses to see doctors or have lab drawn. She sometimes has behaviors where she is mean when staff try to assist her. On 04/19/23 at 08:02 AM, Licensed Nurse (LN) F reported the resident was independent in her room and would not accept assistance for care. She was comfort care and received no physician or dental appointments per her choice. On 04/19/23 at 09:43 AM, Administrative Nurse B reported staff should care plan the resident decision for comfort care and her preferences were. Those are her preferences, and comfort care is not included on the MDS or physician orders. The facility lacked a policy for comfort care. The facility failed to develop a comprehensive care plan for Comfort Care that included the resident preferences and wishes.	F 656		
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	F 657		

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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:
The facility reported a census of 45 residents, with 12 sampled, including four residents sampled for activities of daily living (ADL). Based on observation, interview, and record review, the facility failed to review and revise the care plan for Resident (R) 29 regarding shower preferences.

Findings included:

- The 09/29/22 "Electronic Health Record" (EHR) documented R29 had the following diagnoses of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) and anxiety (mental or emotional reaction

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characterized by apprehension, uncertainty, and irrational fear).

The 09/28/22 "Admission Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of six, indicating severely impaired cognition. R29 was independent with set up assistance of one staff for all ADL, and no bathing occurred in the seven-day look-back period.

The 09/28/22 "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) documented R29 was independent with ADL.

The 03/31/23 "Care Plan" documented R29 preferred early morning showers twice weekly, R29 required one assist for bathing transfers, with clothing management and drying off.

The "Spa Documentation Sheet" for January through April 2023 documented R29 was on the schedule for the evening shift.

On 04/17/23 at 10:36 AM, R 29 observed sitting in his room in his recliner with long facial hair growth, greasy/oily appearing hair, and a dirty shirt.

On 04/18/23 at 01:24 PM, Certified Nurse Aide (CNA) R revealed R29 was on the evening shift schedule.

On 04/18/23 at 03:45 PM, CNA E confirmed R29 was on the evening bathing schedule, but she had not given him a shower.

On 04/18/23 at 04:02 PM, Licensed Nurse (LN) G revealed the admission nurse would obtain the resident's preferences and add them to the care

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F 657	Continued From page 6 plan. LN G stated whichever nurse talked to the family or resident concerning a change in their care would be responsible for updating the care plan. LN G reported she remembered hearing the resident wanted showers in the evening, and staff placed him on the evening schedule, however, she verified the care plan indicated he preferred morning showers. On 04/06/23 at 10:14 AM, Administrative Nurse D revealed she expected her staff to update and follow the care plan for the care of the residents. The facility "Comprehensive Care Plan" revised 07/21/2017, documented the care plans are prepared by a care plan team which included nursing, dietary, activities, and social services. This would include information from the physician, the resident, and the family. The care plan will be updated by charge nurses and care coordinators as events occur. The facility failed to update R29's care plan to guide staff related to this resident's shower preferences.	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 45 residents, with 12 sampled, including four residents sampled for activities of daily living (ADL). Based on observation, interview, and record review, the	F 677		

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facility failed to provide care consistent with standard of practice for Resident (R) 29 to maintain good grooming and personal hygiene related to showers and facial hair removal.

Findings included:

- The 09/29/22 "Electronic Health Record" (EHR) documented R29 had the following diagnoses of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The 09/28/22 "Admission Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of six, indicating severely impaired cognition. R29 was independent with set up assistance of one staff for all ADL.

The 09/28/22 "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) documented R29 was independent with ADL, and that bathing did not occur.

The 3/17/23 "Quarterly MDS" documented R29 required physical help in part of bathing by one staff.

The 03/31/23 "Care Plan" documented R29 preferred early morning showers twice weekly, R29 required one assist for bathing transfers, with clothing management and drying off.

The "Progress Notes" from January 2023 through March 2023, lacked documentation of the resident's refusals of showers/baths.

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The "Spa Documentation Sheet" for January 2023 documented out of nine scheduled opportunities, R29 received five showers, with no shaving noted.

The "Spa Documentation Sheet" for February 2023 documented out of eight scheduled opportunities, R29 received five showers, two with shaving noted, and one refusal noted.

The "Spa Documentation Sheet" for March 2023 documented out of nine scheduled opportunities, R29 received six showers, three with shaving noted, and no refusals noted.

On 04/17/23 at 10:36 AM, R29 observed sitting in his room in his recliner with long facial hair growth, greasy/oily appearing hair, and a dirty shirt.

On 04/17/23 at 10:36 AM, R29 stated he would like assistance with showering and shaving.

On 04/18/23 at 08:02 AM, R29 observed sitting in his room in his recliner with long facial hair growth, greasy/oily appearing hair, and the same dirty shirt.

On 04/17/23 at 08:02 AM, R29 revealed he had gotten no help to shave or shower.

On 04/18/23 at 01:24 PM, certified nurse's aide (CNA) F, revealed she was the shower aide assigned to showers for the day. She stated she would try three times to give a shower to a resident, if they refused all three, she would get the charge nurse. She stated showers were to be documented in the electronic record and on a shower sheet. CNA F revealed R29 was on the

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F 677	Continued From page 9 evening shift schedule. On 04/18/23 at 03:45 PM, CNA E revealed there was not one CNA assigned to give showers on the evening shift, they would just give them per the bath schedule. CNA E stated staff should document them in the electronic record and on the shower sheet whether the resident received a bath or refused. CNA E confirmed R29 was on the evening schedule, and she had not given him a shower. On 04/18/23 at 04:02 PM, Licensed Nurse (LN) G revealed staff should document showers in the electronic record as well as on Spa documentation sheets. LN G confirmed R29 had long facial hair. On 04/06/23 at 10:14 AM, Administrative Nurse D revealed she expected her staff to provide bathing as per the residents' preference, to document it in the electronic record, and on the Spa documentation sheet. The facility "Bathing" policy dated 03/14/15, documented team members who assist residents with bathing would focus on making the bathing experience enjoyable for the resident. Staff were to review the information about bathing found on the resident's bath sheet regarding if the resident wanted a bath or shower. The facility failed to provide care consistent with professional standard of practice, for this resident that required assistance with bathing and facial hair removal, to maintain good grooming, and personal hygiene.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		

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F 690	Continued From page 10 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that 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 census totaled 45 residents with 12	F 690		

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included in the sample, with one resident sampled for catheter care. Based on observation, interview, and record review, the facility failed to provide necessary services to decrease the risk of a urinary tract infection by the failure to ensure the catheter tubing remained below the level of the bladder for one resident. Resident (R) 6.

Findings included:

- Resident (R) 6's signed physician orders dated 04/06/23 revealed the following diagnoses: traumatic subdural hemorrhage (collection of blood on the surface of the brain) without loss of consciousness, chronic obstructive pulmonary disease- COPD (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin) benign prostatic hyperplasia with lower urinary tract symptoms (non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections (UTI).

The "Significant Change in Status Minimum Data Set" (MDS) dated 03/02/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 12 indicating moderate cognitive impairment. The resident required total dependence with daily cares. The resident had an indwelling urinary catheter.

The "Urinary Incontinence Indwelling Catheter Care Area Assessment" (CAA) dated 03/16/23 revealed the resident fatigued easily with repositioning side to side for linen changes and

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catheter care. The resident received Levaquin (an antibiotic medication) for UTI.

Review of the "Care Plan" dated 02/23/23 revealed R 6 required an indwelling urinary catheter related to urinary retention. The care plan guided staff to report symptoms of UTI, avoid obstructions, change the catheter monthly, keep the catheter system in a closed system as much as possible, manipulate the tubing as little as possible during cares, position the bag below the level of the bladder, and provide catheter cares.

Review of the progress notes on 02/19/2023 at 11:20 AM revealed the resident required admission to the hospital for his COPD and UTI. He returned to the facility on 02/23/23. The physician ordered levofloxacin (antibiotic), 500 milligrams, daily for five days for UTI.

Observation on 04/17/23 at 10:16 AM, Licensed Nurse (LN) I and certified nurse's aide (CNA) J entered the resident room to transfer the resident to the toilet for a bowel movement. The sling under the resident as he sat in his wheelchair was then attached to the sit to stand lift. CNA J hung the catheter bag on the mechanical lift above the level of the resident's bladder. Staff transferred the resident to the toilet. When the resident sat on the toilet, the urinary catheter bag, still attached to the mechanical lift, was at the approximate level of the resident's shoulders. CNA J and LN I stood in the bathroom doorway as the resident sat on the toilet. After observation of the urinary catheter at the resident's shoulder height of approximately three minutes, the surveyor questioned the height of the catheter bag. CNA J abruptly grabbed the bag, without

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F 690	Continued From page 13 answering the question, and placed it on a lower bar on the lift. LN I failed to advise CNA J about the placement of the urinary catheter bag. On 04/18/23 at 1:50 PM, Certified Medication Aide (CMA) H reported the resident was dependent on staff for his care and transferred with a sit to stand lift. The resident had a urinary catheter and had a UTI. On 04/19/23 at 07:28 AM CNA J reported the resident was total assistance of two staff with a sit to stand lift. The resident had a urinary catheter. The resident had problems with UTIs. On 04/19/23 at 07:50 AM, LN G reported the CNAs were to do catheter care at least once a shift. Staff should keep the resident's urinary catheter below the level of his bladder. On 04/19/23 at 10:30 AM administrative Nurse B reported she expected all nursing staff to know how to care for a catheter. Review of the facility policy called Catheter Care dated 03/14/15 revealed the tubing is not to be positioned higher than the bladder. The facility failed to provide necessary services to decrease the risk of a urinary tract infection by the failure to ensure the catheter tubing remained below the level of the bladder for this resident.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

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F 812	Continued From page 14	F 812		

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 45 residents. The facility had one main kitchen. The kitchen served food to two dining areas. Based on observation, interview, and record review, the facility failed to properly store food in the main kitchen refrigerators due to foods left uncovered, boxes placed directly on the floor in the kitchen area, and staff failed to discard expired foods in accordance with professional standards for food service safety, to prevent food borne illness to the residents.

Findings included:

- During the brief initial tour of the kitchen, on 04/17/23 at 08:27 AM, observation revealed the following concerns:

1. The walk-in refrigerator had six 16-ounce (oz) containers of grated parmesan cheese with a use by date of 04/07/23.

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F 812	Continued From page 15	F 812		

2. The kitchen had approximately four various food boxes stored directly on the floor with 14 boxes stacked on top of those boxes.

3. The refrigerator had an undated box of lettuce, open to air and wilted.

4. The kitchen had five cutting boards with scratches that covered most of the surface of each of them (making them uncleanable).

5. The kitchen refrigerator had a tray of four oz juice cups with various dates, the front two stacks dated 04/16/23, with the following rows had 10 cups of juice dated 03/28/23, and five cups of juice dated 03/30/23. The juice in the back revealed a date of 04/17/23.

On 04/17/23 at 08:45 AM, Dietary Staff D stated staff should date and seal any unused food products. She stated the juice cups were dated when they were taken out of the freezer. She verified the boxes of food should not be stored directly on the floor.

On 04/18/23 at 02:22 PM, Dietary Manager (DM) C confirmed boxes should not be stored directly on the floor. DM C confirmed staff should discard the expired cheese. DM C stated the juices being in the refrigerator were only good for two to three days. In addition, staff should rotate the juice in the refrigerator.

The facility's policy "Food Storage" revised in 2015 documented all food items would be stored on shelves. All packaged food items would be properly sealed. Refrigerated items should follow a rotation procedure.

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F 812	Continued From page 16 The facility failed to properly store food in the main kitchen refrigerators due to the boxes being directly on the floor and the open food items, also the expired food items for food service to the residents of this facility.	F 812		