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 _____	01/30/2025

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 citations represent the findings of a health resurvey and complaint investigation #KS00192254. The 2567 was sent electronically on 02/11/25.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		

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 _____	01/30/2025

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

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F 582	Continued From page 1	F 582		

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents, with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide the correct CMS form 10123, "Notice of Medicare Non-Coverage" (NOMNC) for two residents, Resident (R) 1 and R23. The facility also failed to include the estimated cost to continue skilled services on CMS form 10055, "Advanced Beneficiary Notice" (ABN), to the resident or their representative for the two residents, R1 and R23. This deficient practice placed the two residents at risk for uninformed decisions regarding skilled care.

Findings included:

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 _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 582	Continued From page 2	F 582		

- The Medicare NOMNC informed beneficiaries of their discharge and their right to an expedited review of the determination to terminate skilled coverage. The ABN form informed the beneficiaries of the estimated cost to continue their services,

The facility's Medicare NOMNC form was not provided to R1 (or their representative), and the ABN form staff provided to R1 (or their representative) lacked the estimated cost to continue services when the resident's skilled services ended on 10/25/24.

The facility's Medicare NOMNC form was not provided to R23 (or their representative), and the ABN form staff provided to R23 (or their representative) lacked the estimated cost to continue services when the resident's skilled services ended on 08/19/24.

On 01/29/25 at 10:00 AM, Administrative Nurse E stated he was not aware that he was supposed to provide the residents or their representatives with the NOMNC forms when skilled services ended. Administrative Nurse E stated the facility had recently changed therapy companies and was unsure of the estimated cost of continuing skilled services.

The facility's "Beneficiary Notices" policy, dated revised 08/24, documented the skilled nursing facility must give notice to the beneficiary at least three days before termination of all Part A services when the beneficiary still had days left in the benefit period. The facility would use the Medicare Provider Non-Coverage, Form CM'S 10123, to inform the beneficiary on how to

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 _____	01/30/2025

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

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F 582	Continued From page 3 request an expedited redetermination. Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN), CMS 10055, must be issued to the resident if the resident intends to continue services and the facility had determined that the services may not be covered under Medicare. The resident must be informed of potential non-coverage and document in the record that the resident understands they are accepting financial liability. The facility failed to provide R1 and R23 the CMS 10123 as required and failed to provide R1 and R23 the estimated cost to continue skilled services. This deficient practice placed the residents at risk for uninformed decisions regarding skilled services.	F 582		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		

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 _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 4	F 623		

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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 _____	01/30/2025

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 623	Continued From page 5	F 623		

Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 12 residents, with two reviewed

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 _____	01/30/2025

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 623	Continued From page 6	F 623		

for hospitalization. Based on observation, record review, and interview, the facility failed to provide written notice for facility-imitated transfer to the hospital for two residents, Resident (R) 4 and R19. This deficient practice placed the residents at risk for uninformed care choices.

Findings included:

- The Electronic Medical Record (EMR) for R4 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin type 2), and dependence on supplemental oxygen.

The "Annual Minimum Data Set" (MDS), dated 10/16/24, documented R4 had intact cognition. R4 was dependent upon staff for toileting, dressing, and personal hygiene. R4 required substantial assistance with showers and transfers. R4 was always incontinent of bladder and bowel, and R4 did not require supplemental oxygen use.

R4's "Medicare 5 Day MDS," dated 01/02/25, documented R4 had moderately impaired cognition. R4 was dependent upon staff for bathing, personal hygiene, toileting, and dressing. R4 was always incontinent of bladder and bowel and required supplemental oxygen use.

R4's "Care Plan" dated 01/23/25, initiated on 10/04/24, directed staff to administer medication as ordered and monitor for effectiveness, elevate the head of the bed, provide oxygen as ordered,

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 _____	01/30/2025

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 623	Continued From page 7	F 623		

and position R4 with proper body alignment for optimal breathing pattern. The care plan directed staff to monitor and document changes in orientation, increased restlessness, anxiety, and air hunger.

The "Progress Note" dated 12/28/24 at 10:10 AM documented R4 was admitted to the hospital for COPD exacerbation.

Review of R4's clinical record lacked evidence the resident or representative was provided a written notice when she was transferred to the hospital.

On 01/28/25 at 01:48 PM, R4 sat in her recliner, her feet elevated, and she had oxygen on.

On 01/29/25 at 04:00 PM, Administrative Staff A verified the facility lacked documentation R4, or their representative was provided a written notice when the resident was transferred to the hospital.

The facility's "Emergency Transfer or Discharge" policy, dated 08/21, documented the facility should make an emergency transfer or discharge when it was in the best interest of the resident. The facility would notify the resident's attending physician and notify the resident's representative. When the resident was transferred, the facility would prepare a transfer to send with the resident.

The facility failed to provide R4 or her representative written notice regarding R4's facility-initiated transfer to the hospital. This deficient practice placed the resident and/or her representative at risk for uninformed care choices.

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 _____	01/30/2025

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 623	Continued From page 8	F 623		

- R19's Electronic Medical Record (EMR) documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin type 2, and multiple sclerosis (MS-progressive disease of the nerve fibers of the brain and spinal cord).

The "Quarterly Minimum Data Set" (MDS), dated 02/04/24, documented R19 had severely impaired cognition. R19 was dependent upon staff for all activities of daily living (ADL), was always incontinent of bladder and bowel, and did not require supplemental oxygen.

R19's "Significant Change MDS," dated 01/16/25, documented R19 had severely impaired cognition. R19 was dependent upon staff for all ADLs, was incontinent of bladder and bowel, and required supplemental oxygen.

R19's "Care Plan" dated 01/21/25, initiated on 03/22/22, directed staff to administer supplemental oxygen as needed. The update, dated 10/22/24, directed staff to give medications as orders to monitor and document side effects and the effectiveness of medications. Staff were directed to monitor for signs and symptoms of respiratory distress and report to the physician as needed.

The "Progress Note," dated 04/06/24 at 02:54 AM, documented R19 was sent to the hospital.

Review of R19's clinical record lacked evidence

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 _____	01/30/2025

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 623	Continued From page 9 the resident or representative was provided written notice when she was transferred to the hospital. On 01/29/25 at 12:15 PM, R19 sat in her wheelchair, feet elevated, and she had oxygen on. On 01/29/25 at 04:00 PM, Administrative Staff A verified the facility lacked documentation R19, or their representative was provided a written notice when the resident was transferred to the hospital. The facility's "Emergency Transfer or Discharge" policy, dated 08/21, documented the facility should make an emergency transfer or discharge when it was in the best interest of the resident. The facility would notify the resident's attending physician and notify the resident's representative. When the resident was transferred, the facility would prepare a transfer to send with the resident. The facility failed to provide R19 or her representative written notice regarding R19's facility-initiated transfer to the hospital. This deficient practice placed the resident and/or her representative at risk for uninformed care choices.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		

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 _____	01/30/2025

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 625	Continued From page 10	F 625		

the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 12, with two reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to provide two residents, Resident (R) 4 and R19, with written information regarding the facility bed hold policy when they were transferred to the hospital. This placed R4 and R19 at risk of not being permitted to return and resume residence in the nursing facility.

Findings included:

- The Electronic Medical Record (EMR) for R4 documented diagnoses of chronic obstructive

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 _____	01/30/2025

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 625	Continued From page 11	F 625		

pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin type 2), and dependence on supplemental oxygen.

The "Annual Minimum Data Set" (MDS), dated 10/16/24, documented R4 had intact cognition. R4 was dependent upon staff for toileting, dressing, and personal hygiene. R4 required substantial assistance with showers and transfers. R4 was always incontinent of bladder and bowel, and R4 did not require supplemental oxygen use.

R4's "Medicare 5 Day MDS," dated 01/02/25, documented R4 had moderately impaired cognition. R4 was dependent upon staff for bathing, personal hygiene, toileting, and dressing. R4 was always incontinent of bladder and bowel and required supplemental oxygen use.

R4's "Care Plan" dated 01/23/25, initiated on 10/04/24, directed staff to administer medication as ordered and monitor for effectiveness, elevate the head of the bed, provide oxygen as ordered, and position R4 with proper body alignment for optimal breathing pattern. The care plan directed staff to monitor and document changes in orientation, increased restlessness, anxiety, and air hunger.

The "Progress Note" dated 12/28/24 at 10:10 AM documented R4 was admitted to the hospital for COPD exacerbation.

Review of R4's clinical record lacked evidence a

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 _____	01/30/2025

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 625	Continued From page 12	F 625		

copy of the bed hold policy was provided to the resident or representative, and the facility was unable to provide evidence upon request.

On 01/28/25 at 01:48 PM, R4 sat in her recliner, her feet elevated, and she had oxygen on.

On 01/29/25 at 04:00 PM, Administrative Staff A verified the facility had not provided R4 or their representative was provided the bed hold notice when the resident was transferred to the hospital.

The facility's "Bed Hold" policy, revised on 05/23, documented the community staff would inform residents upon admission and prior to a transfer for hospitalization of the bed hold policy. When emergency transfers were necessary, the facility would provide the resident or representative with information concerning our bed hold policy per state law as applicable. The bed hold days in excess of our state Medicaid plan are considered noncovered services; a resident would be required to pay for any additional days that he/she wished the facility to hold the bed. Medicaid residents whose bed hold days had expired would be required to provide the facility with written authorization to either reserve or release the bed space within 24 hours of the expiration of such bed hold days.

The facility failed to provide R4 with a copy of the bed hold policy when she was transferred to the hospital. This deficient practice placed the resident at risk of not being permitted to return and resume residence in the nursing facility.

- R19's Electronic Medical Record (EMR) documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and

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 _____	01/30/2025

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 625	Continued From page 13	F 625		

irreversible condition characterized by diminished lung capacity and difficulty or discomfort breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin type 2), and multiple sclerosis (MS - progressive disease of the nerve fibers of the brain and spinal cord).

The "Quarterly Minimum Data Set" (MDS), dated 02/04/24, documented R19 had severely impaired cognition. R19 was dependent upon staff for all activities of daily living (ADL), was always incontinent of bladder and bowel, and did not require supplemental oxygen.

R19's "Significant Change MDS," dated 01/16/25, documented R19 had severely impaired cognition. R19 was dependent upon staff for all ADLs, was incontinent of bladder and bowel, and required supplemental oxygen.

R19's "Care Plan" dated 01/21/25, initiated on 03/22/22, directed staff to administer supplemental oxygen as needed. The update, dated 10/22/24, directed staff to give medications as orders to monitor and document the side effects and effectiveness of medications. Staff were directed to monitor for signs and symptoms of respiratory distress and report to the physician as needed.

The "Progress Note," dated 04/06/24 at 02:54 AM, documented R19 was sent to the hospital.

Review of R19's clinical record lacked evidence a copy of the bed hold policy was provided to the resident or representative, and the facility was unable to provide evidence upon request.

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 _____	01/30/2025

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 625	Continued From page 14 On 01/29/25 at 12:15 PM, R19 sat in her wheelchair, feet elevated, and she had oxygen on. On 01/29/25 at 04:00 PM, Administrative Staff A verified the facility had not provided R19, or their representative was provided the bed hold notice when the resident was transferred to the hospital. The facility's "Bed Hold" policy, revised on 05/23, documented the community staff would inform residents upon admission and prior to a transfer for hospitalization of the bed hold policy. When emergency transfers were necessary, the facility would provide the resident or representative with information concerning our bed hold policy per state law as applicable. The bed hold days in excess of our state Medicaid plan are considered noncovered services; a resident would be required to pay for any additional days that he/she wished the facility to hold the bed. Medicaid residents whose bed hold days had expired would be required to provide the facility with written authorization to either reserve or release the bed space within 24 hours of the expiration of such bed hold days. The facility failed to provide R19 with a copy of the bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.	F 625		
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
	175457	A. BUILDING _____ B. WING _____	01/30/2025

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 812	Continued From page 15	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 had a census of 39 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one of one kitchen. This deficient practice placed the residents who received their meals from the facility's kitchens at risk for foodborne illness.

Findings included:

- On 01/28/25 at 07:42 AM, In a three-door refrigerator, an unsealed plastic bag of yellow shredded cheese, an unlabeled updated 1 1/2-pound (lb.) plastic bag with white cheese, and an unlabeled, undated zip-lock plastic bag with two round slices of meat.

A two-door silver freezer located in the storage room across the hall from the kitchen was an

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 _____	01/30/2025

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 812	Continued From page 16	F 812		

undated three-gallon container of orange sherbet with numerous different-sized dried orange substances around the outside of the container.

An unsealed, approximately 3/4 full, 50 lb. bag of flour and an unsealed, approximately 1/4 full, 50 lb. bag of breadcrumbs.

On 01/28/25 at 08:20 AM, Dietary Staff (DS) BB verified the above findings and stated staff should label and date food items before placing them in the refrigerator. DS BB stated staff should place flour and breadcrumbs in a sealed container after opening the bag.

On 01/29/25 at 10:50 AM, the mopboard around the kitchen's perimeter had numerous different sizes of grayish-black substances on it.
The pipes underneath the dishwasher, approximately two feet long, had numerous areas of different sizes of grayish-black substance.

On 01/29/25 at 10:50 AM, DS CC verified the above finding and stated the dietary staff should clean the mopboard and the pipes underneath the dishwasher.

On 01/30/25 at 09:55 AM, Administrative Nurse D stated the administrator was overseeing the dietary department until next week when the new dietary manager became employed at the facility.

The facility's "Food Safety Requirements Policy," revised 10/2024, documented that all foods stored in the refrigerator or freezer would be covered, labeled, and dated.

The facility's "Sanitation Policy, updated 10/2024, documented all kitchens, kitchen areas, and

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 _____	01/30/2025

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 812	Continued From page 17 dining areas should be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. Kitchen and dining room surfaces not in contact with food would be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. The food services manager was responsible for scheduling staff for regular cleaning of the kitchen and dining areas. The facility failed to store, prepare, distribute, and serve food by professional standards for food service safety for the 39 residents who received their meals from the facility's kitchen. This deficient practice placed the 39 residents at risk for foodborne illness.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849		

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 _____	01/30/2025

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 849	Continued From page 18	F 849		

professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice

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 _____	01/30/2025

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 849	Continued From page 19	F 849		

representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible

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 _____	01/30/2025

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 849	Continued From page 20	F 849		

for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.

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 _____	01/30/2025

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 849	Continued From page 21	F 849		

(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 12 residents, with two reviewed for hospice services. Based on observation, record review, and interview, the facility failed to ensure a communication process between the hospice provider and the facility for Resident (R)25, who was admitted to hospice on 09/08/24, and R19, who was admitted on 01/16/24, which included a plan of care and a description of the services provided which included contact information, visit frequency, medications, and medical equipment. This deficient practice placed R25 and R19 at risk of not receiving needed care.

Findings included:

- R25's Electronic Health Record (EHR) revealed diagnoses of atherosclerotic heart disease (a condition that occurs when plaque (fatty material)

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 _____	01/30/2025

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 849	Continued From page 22	F 849		

builds up in the arteries of the heart), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).

R25's "Quarterly Minimum Data Set" (MDS), dated 12/13/24, documented R25 had a Brief Interview of Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. The MDS document R25 was dependent on staff with toileting, showering, putting on and taking off footwear, and personal hygiene. R25 was partial to moderate assistance with oral hygiene, sitting to standing position, chair to bed/ bed to chair transfers, and toilet transfers. R25 required substantial to maximal staff assist with upper and lower body dressing, sitting to lying, supervision with eating, independent with bed mobility, and propelling in a wheelchair.

R25's "Care Plan," dated 12/16/24, recorded R39 required extensive assistance with most activities of daily living (ADLs). R25's "Care Plan" documented the resident was admitted to [hospice services] on 09/08/24. The care plan directed the staff to administer medications ordered and notify the physician if there is breakthrough pain, assist with supporting the function of ambulation and mobility to the extent needed, talk to the resident during all encounters to avoid isolation and encourage visits from family and friends. The care plan lacked instruction on the services provided by hospice, including 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 _____	01/30/2025

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 849	Continued From page 23	F 849		

frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.

A review of R25's clinical record revealed the resident was admitted to hospice care on 09/06/24. The facility lacked a hospice plan of care.

The hospice agreement documented the hospice plan of care would specify the hospice care and hospice services necessary to meet the needs of the hospice resident. The agreement documented the resident and his/her family would be identified in the initial comprehensive care plan, and staff would update assessments as necessary for the palliation and management of the resident's terminal illness and related conditions. The hospice care plan would provide the frequency of service, interventions to manage pain, drugs, supplies, appliances, and clinical record documentation and would coordinate care with the facility.

01/28/25 at 02:53 PM, R25 self-propelled in a wheelchair to the activity room and sat quietly waiting to have nails done, no signs or symptoms of pain.

01/29/25 at 04:48 PM, Administrative Nurse D verified R25's clinical record lacked a hospice care plan.

01/30/25 at 12:19 PM, Administrative Nurse D verified the facility lacked R25's hospice care plan and stated she had faxed hospice today and requested it. Administrative Nurse D verified the resident's care plan lacked information regarding

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 _____	01/30/2025

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 849	Continued From page 24	F 849		

hospice visits, phone numbers, and medical supplies. Administrative Nurse D stated Administrative Nurse E was responsible for updating care plans.

01/30/25 at 12:19 PM, Administrative Nurse E verified he was responsible for updating the care plans and was unaware the hospice information regarding contact number, medical supplies, phone numbers, and hospice visits were to be included in R25's care plan.

The facility's "Hospice Program Policy," updated 10/2024, documented that hospice would identify in writing the services hospice would be providing, address in the resident's person-centered care plan, and the facility would provide collaboration and coordination of hospice care. The policy-documented facility would ensure the appropriate documents were readily available, which included the hospice plan of care.

The facility failed to coordinate care between the facility and the hospice provider for R25, who received hospice services. This deficient practice placed him at risk for inadequate end-of-life care.
- R19's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin type 2, and multiple sclerosis (MS - progressive disease of the nerve

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 _____	01/30/2025

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 849	Continued From page 25	F 849		

fibers of the brain and spinal cord).

R19's "Significant Change Minimum Data Set" (MDS), dated 01/16/25, documented R19 had severely impaired cognition. R19 was dependent upon staff for all ADLs, was incontinent of bladder and bowel, and required supplemental oxygen.

R19's "Care Plan," dated 01/21/25, documented R19 received hospice services and directed staff to assist her with eating, provide comfort measures as ordered, listen to her concerns, and ensure her call light was in reach. The care plan lacked instruction on the services provided by hospice, including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.

A review of R19's clinical record revealed the resident was admitted to hospice on 01/17/25. The facility lacked a hospice plan of care.

The hospice agreement documented the hospice plan of care would specify the hospice care and hospice services necessary to meet the needs of the hospice resident. The agreement documented the resident and his/her family would be identified in the initial comprehensive care plan, and staff would update assessments as necessary for the palliation and management of the resident's terminal illness and related conditions. The hospice care plan would provide the frequency of service, interventions to manage pain, drugs, supplies, appliances, and clinical record documentation and would coordinate care with the facility.

On 01/29/25 at 12:15 PM, R19 sat in her

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 _____	01/30/2025

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 849	Continued From page 26	F 849		

wheelchair, feet elevated, and she had oxygen on.

01/29/25 at 04:48 PM, Administrative Nurse D verified that R19's clinical record lacked a hospice care plan.

01/30/25 at 12:19 PM, Administrative Nurse D verified the facility lacked R19's hospice care plan and stated she had faxed hospice today and requested it. Administrative Nurse D verified the resident's care plan lacked information regarding hospice visits, phone numbers, and medical supplies. Administrative Nurse D stated Administrative Nurse E was responsible for updating care plans.

01/30/25 at 12:19 PM, Administrative Nurse E verified he was responsible for updating the care plans and was unaware the hospice information regarding contact number, medical supplies, phone numbers, and hospice visits were to be included in R19's care plan.

The facility's "Hospice Program Policy," updated 10/2024, documented hospice would identify in writing the services hospice would be providing, address in the resident's person-centered care plan, and the facility would provide collaboration and coordination of hospice care. The policy-documented facility would ensure the appropriate documents were readily available, which included the hospice plan of care.

The facility failed to coordinate care between the facility and the hospice provider for R19, who received hospice services. This deficient practice placed her at risk for inadequate end-of-life care.