STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175174	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowlark Hills	2121 Meadowlark Road Manhattan, KS 66502

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 117 residents. The sample included 25 residents, with two residents reviewed for discharge. Based on observation, record review, and interview, the facility failed to provide Resident (R) 35 and R5 with written information regarding the facility bed hold policy when she was transferred to the hospital. This placed the residents at risk of not being permitted to return and resume residence in the nursing facility. Findings included: - R35's Electronic Health Record (EHR) revealed diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and celiac disease (a chronic autoimmune disorder where the body's immune system reacts abnormally to gluten- a protein found in wheat, rye, and barley). R35's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R35 had intact cognition. The MDS recorded she required extensive staff assistance with transfers and activities of daily living (ADLs). The Care Area Assessment (CAA), dated 08/15/24, recorded R35 required staff assistance for ADLs and mobility. The CAA documented the resident had moments of occasional confusion at times. On 11/14/24 at 08:40 AM, the Nurse's Notes documented R35 complained of not feeling well and had abdominal pain and nausea. The nurse assessed R35 to have weakness, significant abdominal distention, with hypoactive (slowed intestinal activity) bowel sounds and she complained of pain. On 11/14/24 at 09:18 AM, the Nurse's Notes documented staff received an order to transport R35 to the emergency room for evaluation and treatment and contacted Emergency Medical Services (EMS) for an ambulance. On 11/14/24 at 09:30 AM, the Nurse's Notes documented emergency medical personnel transferred R35 to the hospital. On 11/14/24 at 01:48 PM, the Nurse's Notes documented R35 admitted to the hospital. On 11/14/24 at 02:50 PM, the Nurse's Notes documented R35 was hospitalized for decompression of a significant distended stomach diagnosed on a CT scan and surgical consult for a G-tube (a tube (continued on next page)

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

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inserted through the wall of the abdomen directly into the stomach) placement. On 11/20/24 at 12:08 PM, the Nurse's Notes documented R35 returned to the facility. R35's clinical record lacked a bed hold policy. On 04/08/25 at 09:20 AM, Administrative Nurse D verified the facility lacked evidence of a signed bed hold policy was provided or signed by R35's representative when R35 transferred and admitted to the hospital on [DATE]. The facility's Bed Hold policy dated October 2022, documented the facility would provide the resident and their legal guardian with information to make a decision regarding room holds. The policy documented at move-in, the resident and/or the resident's legal representative and/or designated family member would be provided with room hold authorization information. The room hold would be charged in accordance with the Occupancy Agreement. The policy documented if the legal representative was not present at the time of transfer to another health care facility, a copy of the Room Hold Authorization Form would be mailed to the resident's legal representative or designated The Room Hold Authorization Form. The policy documented it was the responsibility of the household or Social Services team to ensure the resident, the resident's legal representative, or designated family member is aware of his/her responsibilities if he/she wishes to hold the room during the resident's absence from the household. The policy documented that the Licensed Nurse or Social Service Representative assisting with the transfer shall notify Meadowlark Hills by e-mail of the residents' absences from the household. The policy documented that if the resident wanted to hold his/her room, the Room Hold Authorization Form would be completed and sent to health information management and placed in the electronic records interdisciplinary notes. - R5's Electronic Health Record (EHR) revealed diagnoses of encephalopathy (a broad term for any brain disease that alters brain function or structure), chronic kidney disease Stage 3 (moderate kidney damage, where the kidneys struggle to filter waste and fluid, leading to potential health issues like high blood pressure, anemia, and bone problems), venous insufficiency (the veins in your legs struggle to return blood to the heart effectively) morbid obesity (weight that is 80 to 100 pounds over a person's ideal weight) and fluid overload (the body has an excessive amount of fluid, potentially leading to swelling, high blood pressure, and difficulty breathing, among other symptoms). R5's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R5 had intact cognition. The MDS recorded she required extensive staff assistance with transfers and activities of daily living (ADLs). The Care Area Assessment (CAA), dated 08/15/24, recorded R5 required staff assistance with ADLs and mobility and required substantial assistance of two staff with mobility in a wheelchair. The CAA documented R5 had moments of occasional confusion at times. R5's facility Care Plan, dated 12/10/24, recorded R5 had a recent hospitalization for sepsis and right lower leg cellulitis. On 11/26/24 at 11:40 AM, the Nurse's Notes documented R5 was asleep and attempted to wake the resident up and would only respond in one-word statements, upon staff interview the resident was unable to identify the location and month of birth, and noted to have left side facial droop. The notes documented over the course of the assessment R5 had bilateral hand weakness. The nurses' notes documented R5 was assisted to the bathroom, noted to lean to the right side, and staff lifted the resident to (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wheelchair to exit the bathroom. Emergency Medical Services were contacted, and R5 was transported to the hospital at 12:05 PM. On 11/29/24 at 12:35 PM, the Nurse's Notes documented R5 returned to the facility after acute hospitalization for cellulitis of her right leg and acute delirium. The notes documented R5 had increased weakness and required assistance to get out of the wheelchair, however, was able to ambulate with her walker to the recliner. R5's clinical record lacked a bed hold policy. On 04/08/25 at 09:20 AM, Administrative Nurse D verified the facility lacked evidence a signed bed hold policy was provided or signed by the resident's representative when R5 was transferred and admitted to the hospital on [DATE]. The facility's Bed Hold policy dated October 2022, documented the facility would provide the resident and their legal guardian with information to make a decision regarding room holds. The policy documented at move-in, the resident and/or the resident's legal representative and/or designated family member would be provided with room hold authorization information. The room hold would be charged in accordance with the Occupancy Agreement. The policy documented if the legal representative was not present at the time of transfer to another health care facility, a copy of the Room Hold Authorization Form would be mailed to the resident's legal representative or designated The Room Hold Authorization Form. The policy documented it was the responsibility of the household or Social Services team to ensure the resident, the resident's legal representative, or designated family member is aware of his/her responsibilities if he/she wishes to hold the room during the resident's absence from the household. The policy documented that the Licensed Nurse or Social Service Representative assisting with the transfer shall notify Meadowlark Hills by e-mail of the residents' absences from the household. The policy documented that if the resident wanted to hold his/her room, the Room Hold Authorization Form would be completed and sent to health information management and placed in the electronic records interdisciplinary notes. The facility failed to provide R5's representative with a copy of the facility bed hold policy when she was transferred to the hospital. This placed R5 at risk of not being permitted to return and resume residence in the nursing facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 117 residents. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one of one facility kitchen. This placed the residents who received their meals from the facility's kitchen at risk for foodborne illness. Findings included: - On 04/07/25 at 08:35 AM, an initial tour of the Long-Term Care (LTC) main kitchen revealed the following: 1. The shelving unit for clean pans had 4 shelves and the bottom shelf had rust with sheet pans stored on it. All four shelves had chipped blue paint. The clean steam table pans had dried, stuck on pieces of the plastic wrap used when the food was first cooked, and placed on the steam table for a meal. 2. The single food prep table bottom shelf had containers on it with numerous dried food crumbs. The bottom shelf of the double food prep table had numerous crumbs and crumbs on the stored cooking equipment. 3. The flour and sugar bins both had scoops in the bins. 4. A metal knife holder on the side of the brown food prep table had accumulated dust and crumbs on top where the knives slid in. 5. The air conditioning unit blowing toward the stovetop had gummy-looking lint in the grate. 6. The can opener had soiled, dried food particles. On 04/08/25 at 03:30 PM, Dietary Staff CC verified the single prep table needed to be cleaned and immediately performed that task. Dietary CC also noted the rusty and chipped paint on the shelving and the dried plastic on the clean pans. On 04/08/25 at 03:53 PM, Dietary Manager BB was shown the same findings from the day before and stated the staff were to clean the kitchen after the evening meal was prepared. She stated the staff used a dry-erase board to check off the cleaned items but the facility had not kept any records of cleaning. The facility's undated Cleaning in Main Kitchen Procedure policy documented that cleaning logs were posted in each of the areas and were designated by the position responsible for each. Each employee was responsible for completing his or her cleaning list for that day. The food and Beverage Leader would be responsible for ensuring all cleaning tasks were completed as assigned.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 117 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to include a hospice (a program that gives special care to people who are near the end of life) service visit frequency, medications, medical equipment, and the resident representative's preference for Resident (R) 69. This deficient practice placed the resident at risk of not receiving resident-directed end-of-life care. Findings included: - R69's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), dysphagia (swallowing difficulty) following nontraumatic intracranial hemorrhage (a brain bleed), hemiplegia (swallowing difficulty) and hemiparesis (muscular weakness of one half of the body) affecting left non-dominant side, lack of coordination, need for assistance with personal cares, and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R69 had severe cognitive impairment and delusions (untrue, persistent belief or perception held by a person although evidence shows it was untrue). R69 had a functional range of motion impairment of the upper and lower extremities of one side and required substantial/maximal assistance with oral hygiene, bathing, personal hygiene, bed mobility, and transfers. The MDS further documented R69 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and received as-needed pain medication for occasional moderate pain. R69 had a condition or chronic disease that may result in a life expectancy of less than six months and received hospice care. R69's Care Plan, dated 02/26/25, documented R69 had a change of condition and would be utilizing hospice. The care plan documented the hospice provider and the provider's phone number. The care plan directed staff to administer and educate on ordered medications, assist with personal hygiene, provide diet as ordered, and monitor and control the resident's pain. The care plan lacked specifics regarding delegation of hospice staff services, visit frequency, medication, medical equipment, and resident representative preferences. A review of R69's clinical record revealed the resident admitted to hospice care on 08/12/24 with a primary diagnosis of senile degeneration of the brain (a decline in cognitive function, memory, and reasoning, impacting daily life, and is not a normal part of aging). The Physician Progress Note dated 01/07/25, documented the facility nurses confirmed R69 was seen by hospice, and R69 was not aware that the hospice staff seeing her was with hospice, per family preference. On 04/09/25 at 08:30 AM, R69 sat in the dining room, in a high-back wheelchair, dressed, groomed appropriately for the day, and eating independently. On 04/09/25 at 08:34 AM, Certified Nurse Aide (CNA) M reported R69 received hospice services, and hospice staff came two times a week. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/25 at 09:04 AM, Licensed Nurse (LN) G verified that R69 received hospice services and the care plan lacked specifics regarding the hospice provider's care services. LN G also verified that R69's family had not wanted the resident to know of hospice-providing services. The facility's Hospice Agreement contract, dated 09/04/19, documented that the plan of care means the individual's written Plan of Care (POC), established and maintained by Hospice for each Hospice patient. The POC provided for palliation or management of Hospice patients' terminal illness and related conditions and clearly delineated that the Services to be provided by Hospice and Facility were consistent with the Hospice philosophy. The POC was based on an assessment of the patient's current medical, and physical, psychological, social needs, and the living situation reflected the participation of Hospice, the Facility, the patients, and the patient's family, as appropriate, and complies with applicable federal and state laws and regulation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 117 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to maintain standardized infection control practices during a dressing change for Resident (R) 26. This placed the resident at increased risk of wound infection. Findings included: - R26's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with other circulatory complications, cutaneous (related skin) abscess (cavity containing pus and surrounded by inflamed tissue) of buttock, Parkinson's (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) disease, non-pressure chronic ulcer of buttock with fat layer exposed, local infection of the skin and subcutaneous (beneath the skin) tissue, and pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral (large triangular bone/area between the two hip bones) region. The admission Minimum Data Set (MDS), dated [DATE], documented R26 had mildly impaired cognition, no functional range of motion impairment, utilized a walker and wheelchair, required substantial/maximal assistance with toileting hygiene, bathing, upper and lower extremity dressing, personal hygiene, and transfers. R26 also required partial/moderate assistance with bed rolling from side to side. The MDS further documented R26 had one stage three unhealed pressure ulcer/injury on admission, a pressure-reducing device for bed and chair, nutrition/hydration intervention for skin conditions, pressure ulcer/injury care, application of medication/ointment, and nonsurgical dressing other than to the feet. The Pressure Ulcer Care Area Assessment (CAA), dated 02/25/25, documented R26 recently admitted with a stage three pressure injury (full-thickness pressure injury extending through the skin into the tissue below) to his buttocks, which was present on admission. R26's Care Plan dated 02/26/25, documented R26 had a stage three pressure ulcer to his sacrum and left buttock, which was present on admission. R26 had immobility and incontinence. The Care Plan directed staff to administer treatments as ordered, monitor for effectiveness, document treatments weekly, to include measurements of each skin condition breakdown. The Physician Order dated 03/25/25, directed staff to apply skin substitute to the wound bed, cover, and secure with Duoderm (wafer-type moisture-retentive wound dressing used for partial and full-thickness wounds leaking fluids), change every seven days, and as needed. The Wound Weekly Observation Tool dated 04/01/25, documented R26 finished an antibiotic treatment on 08/24/24. The wound measured 3 centimeters (cm) in width, 1.4 cm in length, and 0.2 cm in depth. Placental skin substitute was placed in the wound bed and covered and secured with Duoderm. Staff were to change the dressing every three days and as needed. The Progress Note dated 04/08/25 at 12:16 PM, documented the practitioner saw R26 and evaluated the wound to the right buttock, which continued to improve. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/25 at 10:12 PM, Consultant GG and Licensed Nurse (LN) G donned disposable gloves, and gown, and entered R26's room. Consultant GG assisted the resident in turning onto his left side in the bed, then pulled the clothing down to expose the wound dressing. Consultant GG proceeded to remove the outer dressing (Duoderm), and then the skin replacement. Consultant GG then cleansed the wound with moistened gauze, took measurements, treated it with silver nitrate (treats wounds, ulcers, and burns to prevent infection and promote healing) on the edge of the wound, applied skin replacement, and then covered the wound with a Duoderm. Consultant GG failed to change gloves following cleansing the wound and performing the treatment. On 04/08/25 at 12:33 PM, LN G verified Consultant GG failed to change her gloves during wound care for R26. The facility's Standard Precaution Procedure policy, dated 03/2020, documented that standard precautions were to be used when caring for all residents. The policy directed staff to wear disposable gloves when touching mucous membranes and nonintact skin of a resident. Staff were directed to change gloves between tasks and procedures on the same resident and after contact with material that may contain a high concentration of microorganisms.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility had a census of 117 residents. The sample included 25 residents, with five reviewed for immunizations to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interview, the facility failed to follow the latest guidelines from the Centers for Disease Control and Prevention (CDC) when they failed to offer and administer or obtain an informed declination, or a physician-documented contraindication for Resident (R) 36, R63, R70, R80, and R85, pneumococcal PCV20 vaccination. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease. Findings included: - Review of R36, R63, R70, R80, and R85's clinical medical records lacked evidence the facility and/or the resident representative received or signed consent or informed declination for the current pneumococcal vaccine PCV20. The records lacked evidence of a physician-documented contraindication for use of the vaccine. On 04/08/25 at 01:16 PM, Administrative Nurse E stated the facility had not offered the PCV20 to all residents who were eligible for the vaccine. Administrative Nurse E further stated she would research and discuss the residents' vaccination statuses with the medical director for guidance on how to proceed. The facility's Administration of Pneumococcal Vaccine To Residents Procedure, dated 11/14, documented the facility would obtain, from the resident, legal representative, and physician or their referring facility at move-in, the resident's record related to the immunization schedule. The resident's physician shall be asked to sign facility standing orders that include a pneumococcal vaccination. The resident, who have never received the pneumococcal vaccine, shall be offered the vaccine if agreed to by their physician. If the resident was 65 or less at the time of the last vaccination and more than five years have elapsed since the initial vaccination, a booster dose of the pneumococcal vaccine would be offered. For residents younger than 65, refer to the current CDC guidelines for adult immunization. The facility's medical director shall be consulted or guidance. The administration of pneumococcal vaccine shall be recorded on the resident's health record.