STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175333	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Gardens Health and Rehabilitation Center	700 Cherokee Oskaloosa, KS 66066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility identified a census of 54 residents. The sample included 14 residents, with two for hospitalization. Based on observation, record review, and interviews, the facility failed to provide a written notice of transfer/discharge as soon as practicable, and the facility also failed to provide a bed hold notice with the required information for Resident (R) 38. This deficient practice placed R38 at risk of uninformed choices and miscommunication regarding her care needs and at risk for impaired ability to return to the facility or her same room. Findings included: - R38's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and seizure (violent involuntary series of contractions of a group of muscles). The Annual Minimum Data Set (MDS) dated 08/26/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R38 was dependent on staff assistance for dressing and transfers. The Quarterly MDS dated 04/25/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R38 was dependent on staff assistance for dressing and transfers. R38's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 09/11/24 documented she required assistance with her activities of daily living. R38's Care Plan, dated 02/29/24 documented she was dependent on staff assistance for transfers and dressing. R38's EMR under the Progress Notes tab revealed on 03/04/25 at 01:18 PM an Alert Note documented R38 was transferred by ambulance to the hospital. On 04/21/25 at 03:45 PM a Nurse's Note documented R38 was admitted to the hospital. On 05/06/25 at 11:10 AM a Nurse's Note documented R38 was transferred to the hospital by ambulance. On 05/21/25 at 09:42 AM, R38 propelled herself from the dining room to her room. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/25 at 03:45 PM, Administrative Staff A stated the written notification and bed-hold notice were not sent to R38's legal representative for the three facility-initiated transfers to the hospital. Administrative Staff A stated the social service department was responsible for the written notification and the business office was responsible for the bed-hold notice. On 05/22/25 at 10:17 AM, Dietary Staff/Social Service BB stated the written notification to R38's legal representative had been sent for the three facility-initiated transfers to the hospital. On 05/22/25 at 10:22 AM, Administrative Staff B stated she had not sent out a bed-hold notice to R38's legal representative for the three facility-initiated transfers to the hospital and R38 admitted to the hospital. The facility's undated Bed Hold Notice Upon Transfer policy documented at the time of transfer for hospitalization or therapeutic leave, the facility would provide to the resident and/or the resident representative written notice which specified the duration of the bed-hold policy and addressed information explaining the return of the resident to the next available bed.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. The facility identified a census of 54 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to consistently provide activities on the weekends, the facility identified 28 residents with moderately impaired or severely impaired cognition. This deficient practice had the risk of a decline in physical, mental, and psychosocial well-being and independence for these residents. Findings included: - A review of the facility's Activity Calendars for April and May 2025 that revealed no scheduled activities were listed for the weekends. On 05/21/25 at 09:42 AM, during the Resident council meeting the residents stated there was no consistent if any weekend activities provided by the staff. On 05/22/ 25 at 09:47 AM, Certified Nurse Aide (CNA) M stated on some Sundays church groups would come to the facility and provide church services for some of the residents. CNA M stated sometimes visitors would come and provide music for the residents. On 05/22/25 at 10:03 AM, Licensed Nurse (LN) G stated the nursing staff would put a movie in at times for the residents to watch on the weekends. On 05/22/25 at 10:25 AM, Activity Staff Z stated there were not any scheduled activities on the weekends. Activity Staff Z stated there was an administrative staff member assigned to each weekend, and they could initiate activities. Activity Staff Z stated she felt some activities occurred while the staff assisted the residents with their activities of daily living. The facility's Activities policy dated 08/31/19 documented it was the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility-sponsored group and individual activities and independent activities would be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as encourage both independence and interaction within the community.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 46 residents. The sample included 14 residents, with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to consistently follow a physician's order for daily weights for Resident (R) 9. This deficient practice placed R9 at risk for delay in treatment and untreated illness. Findings included: - R9s Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of need for assistance with personal care, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), obesity (excessive body fat), repeated falls, hypertension (high blood pressure), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), muscle weakness, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), difficulty walking, dementia (a progressive mental disorder characterized by failing memory and confusion), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented that R9 required supervision or touching assistance of staff for eating, was independent for dressing and toileting, and required substantial to maximal assistance with showering. The MDS documented R9 received a diuretic (a medication to promote the formation and excretion of urine) during the observation period. R9's Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 04/10/25 documented R9's urinary incontinence and indwelling catheter CAA triggered secondary to a level of assistance R9 required with her toileting hygiene and toilet transfers, incontinent episodes. The CAA documented the contributing factors included weakness and impaired mobility. R9s Care Plan dated 02/26/24 documented R9 received diuretic therapy related to congestive heart failure. R9's plan of care documented R9 would have a fluctuation of weight due to diuretic use. R9's plan of care documented nursing staff were to administer diuretic medications as ordered by a physician. The plan of care for R9 documented staff were to administer medication as ordered by the physician and monitor R9 for side effects and effectiveness every shift. R9's EMR under the Orders tab revealed the following physician orders: Torsemide (diuretic) oral tablet 20 milligrams (mg) by mouth two times a day for CHF/edema dated 12/04/24. Obtain daily weights everyday shift dated 12/03/23. On 05/21/25 R9's EMR under the Treatment Administration Record (TAR) revealed an updated order: Obtain daily weights, notify the physician if a gain of 3 pounds in one day or gain of 5 pounds in one week everyday shift. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Treatment Administration Record (TAR) from lacked weights for: 02/24/25, 03/01/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/17/25, 03/18/25, 03/21/25, 03/25/25, 03/30/25, 04/01/25, 04/02/25, 04/03/25, 04/04/25, 04/05/25, 04/06/25, 04/07/25, 04/08/25, 04/09/25, 04/10/25, 04/11/25, 04/16/25, 04/19/25, 04/20/25, 04/21/25, 04/22/25, 04/23/25, 04/24/25, 04/26/25, 05/13/25, 05/14/25, and 05/19/25. R9's EMR lacked consistent documentation for the refusal of daily weights. On 05/21/25 at 09:19 AM, R9 laid on her bed on her right side. R9 had her nasal cannula in her nares. On 05/22/25 at 09:46 AM, Certified Nursing Aide (CNA) M stated nursing would let the CNA staff know if residents needed to be weighed. CNA M stated if the CNA was unable to get a resident's weight, the CNA would try again later in the day and notify the nurse. On 05/22/25 at 10:02 AM, Licensed Nurse (LN) G stated that CNAs obtain daily weights, LN G stated if the CNA did not obtain the weight, it was the nurse's duty to try to obtain the resident's weight per the physician's order. LN G stated if a weight was not obtained, it was the nurse on duty's responsibility to ensure the refusal was documented. On 05/22/25 at 10:33 AM, Administrative Nurse D stated that the day shift CNAs obtained daily weights, if the weight was not obtained the CNAs were to notify the charge nurse. Administrative Nurse D stated if the resident refused, the EMR would reflect that the resident refused. The facility's Provision of Physician Ordered Services dated 02/01/20 documented the facility would maintain a schedule of diagnostic tests in accordance with the physician's orders. The facility would provide a reliable process for the proper and consistent provision of physician-ordered services according to professional standards of quality of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. The facility identified a census of 54 residents. The sample included 14 residents, with three reviewed for pressure ulcer prevention (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). Based on interviews, record reviews, and observations, the facility failed to provide a pressure redistribution cushion for Resident (R) 35's wheelchair. This deficient practice places R35 at risk for preventable skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R35's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), and acute kidney failure. R35's Quarterly Minimum Data Set (MDS) dated 04/03/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted he displayed verbal aggression for one to three days during the assessment. The MDS noted he had bilateral lower extremity impairment and used a wheelchair for mobility. The MDS noted he required substantial to maximal assistance with dressing, personal hygiene, oral hygiene, and bed mobility. The MDS noted he required supervision or touch assistance during meals. The MDS noted he was frequently incontinent of bowel and bladder. The MDS noted he had two or more non-injury falls since the last assessment. R35's Dementia Care Aera Assessment (CAA) completed 01/13/25 indicated he was at risk for cognitive loss, incontinence, falls, and skin breakdown. The CAA noted he had difficulties with orientation, memory, and recall. The CAA indicated a plan of care was implemented to minimize the risks related to his cognitive loss. R35's EMR under Assessment revealed a Braden Scale For Predicting Pressure Sore Risk completed on 04/01/25 indicating he was at risk for developing pressure ulcers with a score of 17. R35's Pressure Injury CAA completed 01/13/25 indicated he triggered the potential to develop a pressure ulcer related to his incontinence and reduced level of mobility. The CAA indicated a plan of care was implemented to minimize the risks of developing pressure ulcers. R35's Care Plan initiated 12/29/22 indicated he had a self-care deficit and required assistance with his care needs. The plan noted he required assistance from staff for grooming, toileting, transfers, dressing, personal hygiene, and bathing. The plan noted he was at risk for alterations in skin integrity related to incontinence and the dementia disease process. The plan indicated he was at risk for skin breakdown due to his Braden scale assessment (assessment used to assess the risks of developing a pressure ulcer). The plan instructed staff to apply barrier cream to his buttocks after incontinence episodes. The plan instructed staff to avoid over-drying his skin and to avoid massages over bony prominences. The plan instructed staff to provide frequent turning and repositioning. The plan instructed staff to float the heels of his feet at bedtime and ensure adequate protein intake. The plan instructed the facility to use pressure redistribution surfaces to his bed and wheelchair if indicated. On 05/20/25 at 07:11 AM, R35 sat in his wheelchair in the secondary dining room on the secured (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit. An inspection of his wheelchair revealed no cushion or pressure-reducing padding. R35 sat directly on the wheelchair seat. On 05/22/25 at 09:21 AM, R35 sat in his wheelchair next to the window of the secondary dining room on the secured unit. R35's wheelchair had no cushion or pressure-reducing padding. On 05/22/25 at 09:25 AM, Licensed Nurse (LN) G stated R35 had a pressure relieving cushion in his wheelchair in the past. She stated the padding may have been moved due to his incontinence or it caused him to fall. LN G stated that R35 had decreased sensory awareness and reduced mobility. She stated he sat in his wheelchair most of the time. On 05/22/25 at 09:47 AM, Certified Nurse's Aide (CNA) M stated that R35 had a cushion for his wheelchair. She stated he had a lot of incontinence, and it may have been hard to clean the cushion. CNA M stated she was not sure when the cushion was last in his chair. On 05/22/25 at 10:35 AM, Administrative Nurse D stated R35 had been through several wheelchairs due to his mobility issues. She stated his wheelchair was changed back to his original wheelchair due to continued falls. The facility's Pressure Injury Prevention and Management policy implemented 01/2020 indicated the facility was committed to the prevention of avoidable pressure injuries and the promotion of healing existing injuries. The policy indicated the facility would implement preventative interventions for residents at risk or with existing injuries to include pressure redistribution, nutrition, and supportive surfaces.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R28's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of multiple sclerosis (MS - progressive disease of the nerve fibers of the brain and spinal cord), epilepsy (brain disorder characterized by repeated seizures), convulsions (involuntary series of contractions of a group of muscles), and transient ischemic attack (TIA - temporary episode of inadequate blood supply to the brain). The admission Minimum Data Set (MDS) dated 12/08/24 documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R28 had limitations in bilateral upper and lower extremities of range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R28 was dependent on staff assistance for dressing. He also required substantial to maximum assistance with transfers. The Quarterly MDS dated 03/11/25 documented a BIMS score of six, which indicated severely impaired cognition. The MDS documented that R28 had limited ROM in the bilateral upper and lower extremities. The MDS documented R28 was dependent on staff assistance with dressing and required partial to moderate assistance with transfers. The MDS also documented R28 had two non-injury falls during the observation period. R28's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 12/28/24 documented he required assistance with activities of daily living, had general weakness, and decreased safety awareness. R28's Care Plan, with an initiated date of 03/02/25 documented staff educated R28 on the use of his call light and was encouraged to use the call light for his needs to prevent further falls. The plan of care with an initiated date of 03/09/25 documented R28 was re-educated on the use of his call light when he needed assistance. The plan of care also documented the staff was educated to ensure that the items R28 needed were within his reach. R28's EMR under the Progress Notes tab revealed on 03/02/25 at 04:09 PM a Nurse's Note documented R28 was found sitting on the floor next to his bed. Review of the Fall Investigation dated 03/09/25 at 03:15 PM, noted R28 was found on the floor on his right next to his bed. On 05/22/25 at 08:24 AM, R28 laid asleep on his bed. R28's bedside table was next to the bed with a urinal on the bedside table. On 05/22/25 at 09:47 AM, Certified Nurse Aide (CNA) M stated everyone had access to the resident's care plans and the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA M stated R28 was a fall risk and did not remember to use the call light and wait for staff assistance. CNA M stated all nursing staff were responsible for the safety of each resident. CNA M said nurses were responsible for ensuring all fall precautions were in place and stated the CNAs would get updates for each resident if there was a new intervention put in place for a specific resident. On 05/22/25 at 10:03 AM, Licensed Nurse (LN) G stated everyone had access to the resident's care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan or their Kardex. LN G stated the resident's fall interventions were placed on their care plans. LN G stated the staff were educated on any new interventions placed on the care plan. LN G stated when a resident had a fall the staff should keep a closer eye on the resident. LN G stated the charge nurse and Administrative Nurse D would review all fall interventions that had been placed on the resident's care plan. On 05/22/25 at 10:22 AM, Administrative Nurse D stated R28 had been educated to use his call light after the fall that had occurred on 03/02/25 and then the staff had been educated after R28 had fallen again on 03/09/25. Administrative Nurse D stated she would ensure the resident's care plan was updated with the current fall interventions. Administrative Nurse D stated everyone had access to the resident's care plan and Kardex. The facility's Accidents and Supervision dated 02/01/20 documented the resident environment remained as free of accident hazards, and each resident received adequate supervision and assistive devices to prevent accidents. The facility would identify hazards and risks, implement interventions to reduce hazards and risks, monitor for effectiveness, and modify interventions when necessary. The facility identified a census of 46 residents. The sample included 14 residents, with three residents sampled for accidents and hazards. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 21's fall interventions as directed by her care plan and further failed to implement new interventions for R28. This deficient practice placed R21 and R28 at risk of falls and related injuries. Findings included: - R21's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of encephalopathy (a broad term for any brain disease that alters brain function or structure), hypertension (high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), reduced mobility, contusion of the scalp, fracture of neck of the left femur, fractures o flower end o left radius, obstructive sleep apnea (a common sleep-related breathing disorder where the upper airway collapses, causing brief pauses in breathing during sleep), dementia (a progressive mental disorder characterized by failing memory and confusion), and asthma (a disorder of narrowed airways that causes wheezing and shortness of breath). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R21 was dependent on staff for all activities of daily living (ADL). The MDS documented R21 had two non-injury falls and two injury falls. R21's Falls Care Area Assessment (CAA) dated 12/10/24 documented R21's fall CAA triggered secondary to a history of falling with fracture, and the use of antidepressant medication. R21's CAA documented contributing factors include impaired mobility and generalized weakness. R21's Care Plan dated 11/22/24 documented staff were to ensure R21's call light was within her reach and encourage R21 to use the call light for assistance. R21's plan of care documented staff to respond promptly to R21's request for assistance. R21's plan of care documented R21 should wear appropriate footwear when ambulating or mobilizing in her wheelchair. R21's plan of care documented staff were to follow fall protocol. R21's plan of care documented R21 needed a safe environment with even floors free from spills, and clutter, adequate, glare-free light, a working and reachable call light, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 46 residents. The sample included 14 residents, with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 9's bilevel positive airway pressure (BIPAP - non-invasive ventilation device that provides two different levels of air pressure to assist with breathing) mask and nasal cannula were stored in a sanitary manner. This placed R9 at an increased risk for respiratory infection and complications. Findings included: - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of need for assistance with personal care, diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), obesity (excessive body fat), repeated falls, hypertension (high blood pressure), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), muscle weakness, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), difficulty walking, dementia (a progressive mental disorder characterized by failing memory and confusion), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented that R9 required supervision or touching assistance of staff for eating, was independent in dressing and toileting, and required substantial/maximal assistance with showering. The MDS documented R9 received oxygen therapy and a non-invasive mechanical ventilator during the observation period. R9's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 04/10/25 documented R9 had impaired functional abilities related to general weakness, impaired balance, impaired gait, and mobility. R9's Care Plan dated 03/28/24 documented R9 required oxygen therapy, and staff were to change oxygen tubing, and rinse the oxygen tank filter every week. R9 plan of care documented nursing staff was to apply oxygen therapy as ordered by the physician. R9's plan of care dated 12/12/24 documented R9 used a BIPAP, and nursing staff were to educate R9 on the importance of wearing her oxygen and BIPAP correctly to ensure adequate oxygenation. R9's Care Plan lacked staff direction for the care of R9's oxygen cannula and BIPAP mask. R9's EMR under the Orders tab revealed the following physician orders: Change BIPAP tubing, mask, and storage bag every month every night shift starting on the 5th and ending on the 5th every month dated 12/05/24. BIPAP to be on at night and off during the day. Settings: IPAP: 10CMH20, EPAP: 5CMH20, Rate: 8 every night shift dated 01/31/24. BIPAP to be on at night and off during the day. Settings: IPAP: 10CMH20, EPAP: 5CMH20, Rate: 8 (continued on next page)

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	175333	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Gardens Health and Rehabilitation Center	700 Cherokee Oskaloosa, KS 66066

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 02/01/2024. Change oxygen tubing, storage bag, and rinse filter every Sunday on continuous oxygen use and as needed (PRN) for PRN oxygen use, date the tubing when changed every night shift every Sunday 11/10/2024. Change and date oxygen tubing weekly on Thursdays every day shift 04/10/2025. Change bubbler on oxygen concentrator every 2 weeks, every day shift every 14 days dated 04/10/2025. On 05/021/25 at 09:19 AM, R9 laid on her bed on her right side, R9 had her nasal cannula in her nares. R9's BIPAP mask was laid directly on the bedside table, and an oxygen nasal cannula was laid in the seat of her wheelchair. R9's BIPAP and oxygen nasal cannula were not stored in a sanitary manner. On 05/22/25 at 09:46 AM, Certified Nurse's Aide (CNA) M stated that BIPAP masks and nasal cannulas were to be stored in a bag that was dated. On 05/22/25 at 10:02 AM, Licensed Nurse (LN) G stated that BIPAP masks and nasal cannulas were to be stored in a dated plastic bag, not laid on the bedside table or in the residents' wheelchairs. On 05/22/25 at 10:33 AM, Administrative Nurse D stated that BIPAP masks should be stored in a bag and dated; the mask should not be laid over the bedside table. Administrative Nurse D stated nasal cannulas are also stored in a labeled bag when not in use. The facility's Continuous positive airway pressure (CPAP - ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) and BIPAP cleaning policy documented the facility to clean CPAP and BIPAP equipment by current CDC guidelines and manufacture recommendation to prevent the occurrence or spread of infection.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. The facility identified a census of 54 residents. The sample included 14 residents, with three reviewed for dementia (a progressive mental disorder characterized by failing memory and confusion). Based on interviews, record reviews, and observations, the facility failed to provide consistent dementia-related care services for Resident (R) 35 to promote his highest practicable level of well-being. This deficient practice placed the residents at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - The Medical Diagnosis section within R35's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), and acute kidney failure. R35's Quarterly Minimum Data Set (MDS) dated 04/03/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted he displayed verbal aggression for one to three days during the assessment. The MDS noted he had bilateral lower extremity impairment and used a wheelchair for mobility. The MDS noted he had two or more non-injury falls since his last assessment. The MDS noted he had frequent bowel and bladder incontinence. The MDS noted he required substantial to maximal assistance with dressing, personal hygiene, oral hygiene, and bed mobility. The MDS noted he required supervision or touch assistance during meals. The MDS noted he was frequently incontinent of bowel and bladder. The MDS noted he had two or more non-injury falls since the last assessment. R35's Dementia Care Aera Assessment (CAA) completed 01/13/25 indicated he was at risk for cognitive loss, incontinence, falls, and skin breakdown. The CAA noted he had difficulties with orientation, memory, and recall. The CAA indicated a plan of care was implemented to minimize the risks of his cognitive loss. R35's Care Plan initiated 12/29/22 indicated he had a self-care deficit and required assistance with his care needs. The plan noted he required assistance from staff for grooming, toileting, transfers, dressing, personal hygiene, and bathing. The plan indicated he was moved to the secured unit due to his risk of elopement. The plan noted he wandered the secured unit regularly. The plan instructed staff to keep R35 engaged in activities throughout the day, calmly talk to him, and anticipate his needs. The plan indicated he had aggressive behaviors but lacked interventions for staff to utilize during these behaviors. R35's EMR under Progress Notes revealed a Behavioral Note completed 11/01/24 that he had behaviors of entering peers' rooms. The note revealed that R35 was not redirectable during staff attempts. The note revealed he received medication to help him calm down. The note lacked other non-pharmacological behavioral interventions attempted by staff. R35's EMR under Progress Notes revealed a Behavioral Note completed 11/01/24 that staff found R35 in the unit's secured bathroom on the floor. The note revealed he had a non-injury fall as he attempted to self-toilet himself. The note indicated he had no injuries. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's EMR under Progress Notes revealed a Behavioral Note completed 01/30/25 indicated R35 was aggressive during staff care and redirection. The note revealed R35 grabbed, punched, pinched, and swung at staff. The note lacked behavioral interventions attempted by staff. On 05/21/25 at 12:20 PM, R35 sat in his wheelchair in the hallway next to the secured unit's dining area. R35 wheeled himself from the dining area to R53's room. R35 entered the room and went to the dresser. R35 opened R53's dresser and looked through his belongings. At 12:25 PM, R35 exited the room and went down the hall to the emergency exit. R35 stopped to look in several other rooms but did not enter the other rooms. On 05/22/25 at 09:30 AM, Licensed Nurse (LN) G stated R35 was difficult to keep engaged in activities due to his severe cognitive impairment. She stated the residents on the secured unit were not to enter pes rooms or the locked areas due to safety concerns. She stated the bathroom, closets, and nursing offices were locked at all times. On 05/22/25 at 09:47 AM, Certified Nurse's Aide (CNA) M stated R35 liked to wander on the secured unit but was not allowed to go into peer's rooms. She stated staff were expected to redirect him and provide activities to distract him. On 05/22/25 at 10:35 AM, Administrative Nurse D stated that R35 loved to wander all over the unit, and at times was difficult to keep him out of other rooms. She stated staff were expected to supervise and provide activities to help maintain his interest. The facility's Dementia Care policy revised 10/2019 indicated the facility would implement strategies and approaches to address triggers and behaviors to minimize the distress in the unit and ensure each resident maintained the highest practicable level of physical, mental, and psycho-social functioning as possible.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility identified a census of 54 residents, eight residents on a puree-textured diet. Based on observation, record review, and interviews, the facility failed to follow nutritionally approved recipes during the preparation of the facility's puree-based meals. This deficient practice placed eight residents at risk for complications related to nutritional impairment. Findings included: - On 05/21/25 at 11:05 AM, Dietary Staff CC placed cooked pork chops into the food processor and then started the machine. Dietary Staff CC then added several scoops of gravy into the food processor. Dietary Staff CC checked the consistency of the pork chops. Dietary Staff CC then added several more scoops of gravy into the food processor with the cooked pork chops. Dietary Staff CC checked the food consistency and then placed the pureed pork chops into a pan. Dietary Staff CC stated he added four cups of gravy into the food processor with cooked pork chops. On 05/22/25 at 10:17 AM, Dietary Staff/Social Service BB stated Dietary Staff CC should have followed the recipe for pureed pork chops. Dietary Staff BB stated what Dietary Staff CC had added to the pureed pork chops had added more calories to the food and had not diminished the nutritional value of the food. The facility's undated Texture and Consistency-Modified Diets) policy documented the food and nutrition services department would be responsible for preparing and serving the diet as ordered, including the texture and fluid consistency. The policy directed care would be taken to serve the foods and fluids as ordered on the consistency-altered diet or fluids.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility identified a census of 46 residents. The facility identified seven residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure Resident (R) 9 and R36 nasal cannulas and BIPAP masks were stored in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Findings included: - On 05/21/25 at 09:19 AM, R9 laid on her bed on her right side, R9 had her nasal cannula in her nares. R9's BIPAP mask laid directly on the bedside table, and an oxygen nasal cannula laid in the seat of her wheelchair. R9's BIPAP and oxygen nasal cannula were not stored in a sanitary manner. On 05/21/25 at 10:01 AM, R36's oxygen nasal cannula was wrapped around the handle of the oxygen canister in R36's room. R36's nasal cannula was not stored in a sanitary manner. On 05/22/25 at 09:46 AM, Certified Nurse's Aide (CNA) M stated BIPAP masks and nasal cannulas were to be stored in a bag that was dated. On 05/22/25 at 10:02 AM, Licensed Nurse (LN) G stated that BIPAP masks and nasal cannulas were to be stored in a dated plastic bag, not laid on the bedside table or in the residents' wheelchairs. On 05/22/25 at 10:33 AM, Administrative Nurse D stated that BIPAP masks should be stored in a bag and dated; the mask should not be laid over the bedside table. Administrative Nurse D stated nasal cannulas are also stored in a labeled bag when not in use. The facility's Infection Prevention and Control Program reviewed 08/15/22 documented the facility had established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection as per accepted national standards and guidelines.

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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 identified a census of 46 residents. The sample included 14 residents, with five reviewed for immunization status. Based on record review and interviews, the facility failed to obtain consent or declinations for the Pneumococcal Conjugate Vaccine (PCV20 - vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Residents (R) 36, R2, R35, and R21. This placed the residents at increased risk for complications related to pneumonia. Findings included: - Review of R36's clinical record revealed the PCV23 was pending on 10/29/24, R36's clinical record lacked documentation that the PCV20 was offered or declined and lacked documentation of a historical administration or a physician-documented contraindication. Review of R2's clinical record revealed the PCV13 was administrated on 03/24/24. R2's clinical record lacked documentation that the PCV20 was offered or declined and lacked documentation of a historical administration or a physician-documented contraindication. Review of R35's clinical record documented R35's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or a physician-documented contraindication. Review of R21's clinical record revealed that PCV13 was administrated on 02/14/16, R21's clinical record lacked documentation that PCV20 was offered or declined and lacked documentation of a historical administration or a physician-documented contraindication. On 05/22/25 at 10:02 AM, Licensed Nurse (LN) G stated the nurse in charge would ask about immunization on admission, this information would be charted and given to the director of nursing to follow-up. On 05/22/25 at 10:33 AM, Administrative Nurse D stated immunizations were offered on admission and yearly. Administrative Nurse D stated she had delegated immunization tasks to the assistant director of nursing. Administrative Nurse D stated the facility tried to get declination or consent on admission. She stated the information was sent to the pharmacy, and the pharmacy would decide what immunization each resident would need. The facility's Pneumococcal Vaccine dated 12/04/24 documented the facility would offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Each resident would be offered a pneumococcal immunization unless it was medially contraindicated or the resident had already been immunized Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders.