STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175474	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Valley Manor	1009 N Marshall Chapman, KS 67431

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility had a census of 31 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 10055, Advanced Beneficiary Notice (ABN), to the resident or their representative for Resident (R) 28, and R137. This placed the residents at risk for uninformed decisions regarding skilled services. Findings included: - The Medicare ABN form informed the beneficiaries Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included options for the beneficiary to (1) receive specified services listed, and bill Medicare for an official decision on payment. I understand that if Medicare does not pay, I will be responsible for the payment, but I can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for payment of services. (3) I do not want the listed services. The facility's Medicare ABN form staff provided to R28 (or their representative) was CMS-R-131 when the resident's skilled services ended on 06/12/24. The facility's Medicare ABN form staff provided to R137 (or their representative) was form CMS-R-131 when the resident's skilled services ended on 04/01/24. On 08/17/24 at 09:00 AM, Social Services X stated she did not realize she had been providing the families with the incorrect CMS form. The facility's ABN Policy, revised 11/01/19, documented the facility would provide timely notices regarding Medicare eligibility and coverage. The policy documented for Part A items and services; the facility should use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form CMS 10055. The facility failed to provide R28 and R137 the correct ABN form CMS 10055 as required. This placed the residents at risk for uninformed decisions regarding skilled services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to ensure staff possessed the necessary knowledge and competency to respond immediately when a hospice Certified Nurse Aide (CNA) removed Resident (R) R29's fentanyl (narcotic pain medication with a high risk for abuse) patch and further failed to dispose of the patch per the standards of practice and manufactures instructions. This placed the residents at risk for inadequate care. Findings included- - On 09/16/24 at 02:25 PM, observation revealed R29 rested in bed on her back with oxygen on per nasal cannula. R29 reported the hospice CNA removed her fentanyl patch while providing R29 a bed bath today after stating that it was expired. On 09/16/24 at 02:28 PM, when asked about the removal of R29's fentanyl patch, Licensed Nurse (LN) H stated the hospice CNA told her the patch came off when providing R29 a bed bath. LN H stated she did not remember what the CNA said she did with the fentanyl patch. LN H stated she thought the CNA tossed it in R29's trash can but the aide had already left so she could not ask her. Observation revealed LN H and LN I went to R29's room, applied gloves, and searched the bathroom trash can and the bedside trash can but the fentanyl patch was not found. LN H then searched R29's chest and back area, and the bed but the fentanyl patch was not found. LN H went back to the nurse's station, phoned hospice services, and spoke to the hospice CNA. LN H said the hospice CNA had reported to her she had taken the trash from R29's room and placed it in the shower room across the hall. Further observation revealed LN H went to the shower room, applied gloves, and searched the trash can. LN H found the fentanyl patch, folded in half in the trash can; it was dated 09/13/24. LN H discarded the fentanyl patch in Sharp's container (a specialized, puncture-resistant container used to safely dispose of sharp objects, such as needles and syringes) on the medication cart. LN H stated that R29 was scheduled to receive a new fentanyl patch at 04:00 PM. On 09/17/24 at 03:36 PM, LN G stated if a CNA reported to her that R29's fentanyl patch had come off and the CNA tossed it in the trash can, she would immediately go to R29's room and retrieve it. LN G stated a fentanyl path was an important medication, and a CNA should not be taking it off and discarding it. On 9/18/24 at 12:03 PM, Administrative Nurse D stated if a CNA reported to the nurse a resident's fentanyl patch came off and she tossed it in the trash can, the nurse should immediately go and retrieve it and discard it in Sharp's container. The Food and Drug Administration (FDA.Gov) instructs that fentanyl patches contain a powerful opioid medicine that can be dangerous to people it's not prescribed for. This adhesive patch delivers a strong pain medicine through the skin. Even after a patch is used, a lot of the medicine remains. Fentanyl comes with instructions to fold and flush used or leftover patches. The facility failed to ensure staff possessed the skill and competency required to safely monitor and dispose of R29's fentanyl patch. This placed the residents at risk for inadequate care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist identified and reported Resident (R) 26's as needed (PRN) Haldol (antipsychotic medication that treats mental and neurological disorders) did not have a 14-day stop date. This placed the resident at risk for unnecessary psychotropic (alters mood or thought) medications. Findings included: - R26's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R26 had severely impaired cognition. R26 required minimal staff supervision for activities of daily living (ADLs). R26 had delusions, verbal and other behaviors directed towards others one to three days a week, and received antianxiety, antipsychotic, and antidepressant medication. R26's Care Plan, dated 04/02/24, directed the staff to monitor the resident for physical aggression, R26 had threatened and struck out at staff due to anger. R26 had poor impulse control due to frontal lobe dementia and was a new resident of the facility. The care plan directed staff to de-escalate the resident by calmly allowing him to talk, give him reassurance, and distract him once he calms down. The care plan directed staff to administer medications as ordered and document if effective. The Physician Order, dated 04/23/24 directed staff to administer Haldol (an antipsychotic), 1 milligram (mg), by mouth, every hour, PRN as needed for aggression. The order lacked a stop date. The Medication Administration Record for August 2024 documented R26 received the PRN medication on 08/01/24 and 08/12/24. The Medication Administration Record for September 2024 documented R26 received the PRN medication on 09/14/24. R26's Consultant Pharmacist monthly medication reviews completed on 05/26/24, 06/16/24, 07/22/24, and 08/20/24 lacked evidence the CP identified and reported the PRN Haldol with no stop date. On 09/17/24 at 09:40 AM, observation revealed Certified Medication Aide (CMA) R administered R26's morning medication without difficulty. On 09/18/24 at 02:40 PM, Administrative Nurse D verified R26's Haldol did not have a stop date and the consultant pharmacist did not notify her of the need for a stop date. The Consultant Pharmacist Services Provider-Requirements, policy dated 07/29/2023, documented the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consulting pharmacist agrees to render the required services in accordance with local, state, and federal laws, regulations, guidelines, facility policies and procedures, and community standards of practice. The consulting pharmacist provides services, including but not limited to reviewing the medication regimen of each resident at least monthly, utilizing federally mandated standards of care in addition to other applicable standards, and documenting the review and findings in the resident's medical record. Reviewing medication administration records (MARs) and physician orders at least monthly to assure proper documentation of medication orders and administration of medications to residents. The consultant pharmacist would submit a written report of findings and recommendations resulting from the review of the medication regimen and nursing. The facility failed to ensure the CP identified and reported R26's PRN Haldol did not have a 14-day stop date. This placed the resident at risk for unnecessary psychotropic medications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility has a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R)26's as-needed (PRN) antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) had a 14-day stop date. This placed the resident at risk for unnecessary psychotropic (alters mood or thought) medications and related complications. Findings included: - R26's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R26 had severely impaired cognition. R26 required minimal staff supervision for activities of daily living (ADLs). R26 had delusions, verbal and other behaviors directed towards others one to three days a week, and received antianxiety, antipsychotic, and antidepressant medication. R26's Care Plan, dated 04/02/24, directed the staff to monitor the resident for physical aggression, R26 had threatened and struck out at staff due to anger. R26 had poor impulse control due to frontal lobe dementia and was a new resident of the facility. The care plan directed staff to de-escalate the resident by calmly allowing him to talk, give him reassurance, and distract him once he calms down. The care plan directed staff to administer medications as ordered and document if effective. The Physician Order, dated 04/23/24 directed staff to administer Haldol (an antipsychotic), 1 milligrams (mg), by mouth, every hour, PRN as needed for aggression. The order lacked a stop date. The Medication Administration Record for August 2024 documented R26 received the PRN medication on 08/01/24 and 08/12/24. The Medication Administration Record for September 2024 documented R26 received the PRN medication on 09/14/24. On 09/17/24 at 09:40 AM, observation revealed Certified Medication Aide (CMA) R administered R26's morning medication without difficulty. On 09/17/23 at 10:30 PM, Administrative Nurse D verified R26's Haldol did not have a stop date. Administrative Nurse D stated the consultant pharmacist did not notify her that the Haldol did not have a stop date. The facility's Monitoring of Antipsychotics policy dated April 12, 2016, documented that residents would receive antipsychotic medications only when medically necessary. Every effort would be made to (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure that residents who use antipsychotics receive the intended benefit of the medication and that unwanted side effects are kept to a minimum. The facility failed to obtain the required 14-day stop date for R26's PRN antipsychotic medication. This placed the resident at risk for unnecessary medications and related complications.The Physician Order, dated 04/23/24 directed staff to administer Haldol (an antipsychotic), 1 milligrams (mg), by mouth, every hour, PRN as needed for aggression. The order lacked a stop date. The Medication Administration Record for August 2024 documented R26 received the PRN medication on 08/01/24 and 08/12/24. The Medication Administration Record for September 2024 documented R26 received the PRN medication on 09/14/24. On 09/17/24 at 09:40 AM, observation revealed Certified Medication Aide (CMA) R administered R26's morning medication without difficulty. On 09/17/23 at 10:30 PM, Administrative Nurse D verified R26's Haldol did not have a stop date. Administrative Nurse D stated the consultant pharmacist did not notify her that the Haldol did not have a stop date. The facility's Monitoring of Antipsychotics policy dated April 12, 2016, documented residents would receive antipsychotic medications only when medically necessary. Every effort would be made to ensure that residents who use antipsychotics receive the intended benefit of the medication and that unwanted side effects are kept to a minimum. The facility failed to obtain the required 14-day stop date for R26's PRN antipsychotic medication. This placed the resident at risk for unnecessary medications and related complications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure one of the five residents, Resident (R) 19, reviewed during the medication administration pass remained free of medication errors. This placed the resident at risk for adverse reactions from the medication. Findings included: - R19's Electronic Health Record (EHR) revealed diagnosis of neoplasm of the esophagus (cancer that forms in the lining of the esophagus or throat), gastroesophageal reflux (GERD-backflow of stomach contents to the esophagus), hypertension (HTN-elevated blood pressure), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) R19's Quarterly Change Minimum Data Set (MDS), dated [DATE], recorded R19 had a Brief Interview for Mental Status score of 14 and was cognitively intact. The MDS recorded he required extensive assistance from two staff with bed mobility and transfers. The MDS documented the resident received hospice services. R19's Care Plan, dated 07/16/24, recorded that R19 required extensive assistance with most activities of daily living (ADL) care. R19's Care Plan documented the resident received hospice services due to a terminal prognosis and directed staff to adjust the provision of ADLs to compensate for R19's change in needs. The care plan directed the staff to observe the resident closely for signs of pain, administer pain medications as ordered, and notify the physician if there is breakthrough pain. The Physician Order, dated 08/13/24, directed the staff to administer Wellbutrin XL (medication used to treat depression) oral tablet extended release 24-hour 150 milligrams (mg,), give one tablet via the feeding tube in the morning for increased anxiety and depression. On 09/17/24 at 08:00 AM, observation revealed License Nurse (LN) G crushed R19's morning medications including the Wellbutrin 150 milligram (mg), XL extended-release pill, then placed the crushed medication in a plastic medication cup. LN G took a spoon, removed the Wellbutrin pill coating, and discarded it. Continued observation revealed LN G administered the crushed medication with water in the resident's gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). On 09/17/24 at 08:30 AM, LN G stated R19 received his medications crushed due to administration through the G-tube. LN G stated she had voiced her concern about crushing the extended-release medication to hospice and the order had not been changed. On 09/17/24 at 09:30 AM, Administrative Nurse D verified the extended-release medication should not be crushed and said it should be administered whole due to the extended release of the medication. Administrative Nurse D said she would contact the physician to get the medication in another form that can be crushed and administered through the G-tube. Medlineplus.gov directed that sustained-release and extended-release tablets should be taken whole; do not split, chew, or crush them. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Medication Administration policy, dated 01/04/24, documented that medications are administered as prescribed, in accordance with good nursing principles and practices and by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications. The policy documented that if safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or a tube-fed, using the following guidelines: Long-acting or enteric-coated dosage forms should generally not be crushed and require a physician-specific order to do so. The facility failed to ensure R19 remained free from medication errors when staff crushed an extended-release medication prior to administration. This placed the resident at risk for adverse reactions from the medication.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to correctly prepare a pureed diet for three residents who required the modified textured food to retain both nutritive value and palatability. This placed the affected residents at risk for impaired nutrition and decreased quality of life. Findings included: - On 09/17/24 at 10:30 AM, observation revealed Dietary Staff (DS) BB prepared three pureed diets. DS BB placed three ounces of chicken fried steak in the Xtreme blender (a food processor) and added two teaspoons of beef base mixed with 1.5 cups of water, and 1.5 slices of bread. DS BB blended the meat to a thin consistency and emptied the blended chicken fried steak into a metal pan and placed the pan into the oven. Observation revealed DS BB then placed three cups of cabbage in the Xtreme blender, 1.5 slices of bread, and two teaspoons of vegetable base mixed in one-half of a cup of water and mixed the ingredients to a puree texture. DS BB emptied the pureed cabbage into a metal pan and placed the pan into the warming well. Continued observation revealed DS BB placed three pieces of chocolate and vanilla marble birthday cake in a bullet-style personal blender and was going to add 2.5 cups of milk. Upon questioning the amount of liquid, DS BB asked the Certified Dietary Manager who instructed DS BB to use one cup of milk and add more if needed. Continued observation revealed the consistency was a runny liquid after adding one cup of milk, so DS BB added four teaspoons of thickener to obtain the correct pureed texture. On 09/17/24 at 02:40 PM, DS BB verified he did not follow a pureed recipe. DS BB did locate a puree recipe book in the kitchen that had copies of the food he prepared for the lunch meal with the correct amounts to obtain the appropriate pureed texture for the residents. The facility's Texture and consistency-Modified Diets policy, dated 2017, documented that texture and consistency-modified diets would be individualized with modifications made by the speech-language pathologist (SLP) and physician with the registered dietician nutritionist (RD) or designee and director of food and nutrition services. The food and nutrition services department would be responsible for preparing and serving the diet texture and fluid consistency as ordered. Care would be taken to serve the food and fluids as ordered by the physician or designee using the diet order form or other facility communication. The facility failed to prepare three pureed diets using professional standards for food service to maintain both nutritive and palatability. This placed the affected residents at risk for impaired nutrition and decreased quality of life.

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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 31 residents. The sample included 12 residents with two reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)19 and R29. This placed the residents at risk for inappropriate end-of-life care. Findings included: - R19's Electronic Health Record (EHR) revealed diagnosis of neoplasm of the esophagus (cancer that forms in the lining of the esophagus or throat), gastroesophageal reflux (GERD-backflow of stomach contents to the esophagus), hypertension (HTN-elevated blood pressure), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R19's Quarterly Change Minimum Data Set (MDS), dated [DATE], recorded R19 had a Brief Interview for Mental Status score of 14 and was cognitively intact. The MDS recorded he required extensive assistance from two staff with bed mobility and transfers. The MDS documented the resident received hospice services. R19'sCare Plan, dated 07/16/24, recorded that R19 required extensive assistance with most activities of daily living (ADL) care. R19's Care Plan documented the resident received hospice services due to a terminal prognosis and directed staff to adjust the provision of ADLs to compensate for R19's change in needs. The care plan directed the staff to observe the resident closely for signs of pain, administer pain medications ordered, and notify the physician if there is breakthrough pain. The care plan lacked instruction on the services provided by hospice visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice provider including their address and phone number. A review of R19's medical records revealed the resident was admitted to hospice care on 04/09/24. The facility had a plan of care provided by hospice in a communication book but it did not list specifics on the care provided. On 09/16/24 at 02:40 PM, R19 sat in a recliner in his room. He had a musician playing the guitar at his bedside. On 09/17/24 at 11:30 AM, Administrative Nurse D verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan. The Coordination of Hospice Services policy, dated 02/01/20, documented the facility would maintain a written agreement with hospice providers that specifies the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding resident's care. The facility and hospice provider would coordinate a plan of care would implement interventions in accordance with the resident's needs, and goals, and recognize standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extent possible. The plan of care would identify the care and services that each entity would provide to meet the needs of the resident and his/her expressed desire for hospice care. The facility would communicate with the hospice and identify, communicate, follow, and document all interventions put into place by the hospice and the facility. The facility would monitor and evaluate the residents to the hospice care plan. All residents receiving hospice would continue to receive the same facility services as the residents who have not elected hospice. The facility would immediately contact and communicate with the hospice staff, attending physician/practitioner, and the family resident representative regarding significant changes in the resident's status, clinical complications, or emergent situations. The facility failed to coordinate care between the facility and the hospice provider for R19, who received hospice services. This deficient practice placed him at risk for inappropriate end-of-life care - R29's Electronic Health Record (EHR) revealed diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and congestive heart failure (CHF-a condition with low heart output and body becomes congested with fluid). R29's admission Minimum Data Set (MDS), dated 08/21/24, recorded R29 had a Brief Interview for Mental Status score of 12, which indicated mildly impaired cognition. The MDS documented R29 was dependent on staff for most activities of daily living (ADLs). The MDS documented the resident received hospice services. R29'sCare Plan, dated 08/20/24, documented R29's dependence on staff with most ADLs. The care plan documented that R29 had a mood problem retaining to her disease process of end-stage COPD and CHF and received hospice services. The care plan instructed staff to administer medications as the physician ordered, monitor and document for side effects and effectiveness of the medications, and report as needed (PRN) any verbalization of risk for harm to self or acute episodes of feeling or sadness to the physician. The plan lacked interventions related to the equipment, supplies, and medications provided or the frequency of hospice visits. The Hospice Agreement for the provision of hospice services to nursing home residents between R29's hospice provider and the facility dated 01/01/24 documented the hospice shall develop, at the time an eligible resident is admitted into the hospice program, a hospice care plan in cooperation with the interdisciplinary care team of the care home. On 09/16/24 at 02:25 PM, observation revealed R29 resting in bed on her back with oxygen on per nasal cannula. On 9/17/24 at 12:02 PM, Administrative Nurse D verified the facility lacked specific information on the facility's care plan that coordinated with the hospice care plan. The Coordination of Hospice Services policy, dated 02/01/20, documented the facility would maintain a written agreement with hospice providers that specifies the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding resident's care. The facility and hospice provider would coordinate a plan of care would implement interventions in accordance with the resident's needs, and goals, and recognize standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175474	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Valley Manor	1009 N Marshall Chapman, KS 67431

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extent possible. The plan of care would identify the care and services that each entity would provide to meet the needs of the resident and his/her expressed desire for hospice care. The facility would communicate with the hospice and identify, communicate, follow, and document all interventions put into place by the hospice and the facility. The facility would monitor and evaluate the residents to the hospice care plan. All residents receiving hospice would continue to receive the same facility services as the residents who have not elected hospice. The facility would immediately contact and communicate with the hospice staff, attending physician/practitioner, and the family resident representative regarding significant changes in the resident's status, clinical complications, or emergent situations. The facility failed to coordinate care between the facility and the hospice provider for R29. This placed the resident at risk for inadequate end-of-life care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility had a census of 31 residents. The sample included 12 residents. Based on record review and interviews the facility failed to conduct a risk assessment to identify risks and implement a water management program to mitigate the risk of Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by Legionella) and other waterborne pathogens. This placed the residents in the facility at risk for infectious disease. Findings Included: - On 09/17/24 at 03:00 PM, Maintenance Staff U verified he was not aware of any routine facility water management checks and verified the facility had some rooms presently unoccupied. Maintenance Staff U stated housekeeping staff flushed the water in the unoccupied rooms on occasion, but not routinely. On 09/18/24 at 08:00 AM, Administrative Nurse E verified the facility did not have a system to check for standing water in any unoccupied rooms or other potential areas to mitigate potential Legionella growth inside the facility. The facility's Water Management Procedure policy, dated 08/14/24, documented the facility would develop a program to reduce the risk of Legionella growth and spread. The policy documented the water management team would review the elements of the program at least once a year and revise the program as needed. The facility would identify building water systems for which Legionella control measures are needed; assess how much risk the hazardous conditions in those water systems pose; and apply control measures to reduce the hazardous conditions, whenever possible, to prevent Legionella growth and spread. The facility would make sure the program is running as designed and is effective. The facility failed to conduct a risk assessment to identify risks and implement a water management program to mitigate the risk of waterborne pathogens placing the residents who resided in the facility at risk of contracting Legionella disease.