STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175185	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SMOKY HILL REHABILITATION CENTER	1007 JOHNSTOWN AVENUE SALINA, KS 67401

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 0551 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give the resident's representative the ability to exercise the resident's rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to attempt to provide Resident (R) 168 the right to designate a representative or Durable Power of Attorney (DPOA) before her cognition declined. Findings included: - R168's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS documented the resident required limited assistance of one staff with transfers, bed mobility, dressing, and personal hygiene. The Cognition Care Area Assessment (CAA), dated [DATE], documented the resident had severe cognitive impairment, inattention, and disorganized thinking. The Cognition Care Plan, dated [DATE], documented the resident had major [MEDICAL CONDITION] (MDD) and impaired cognitive function/impaired thought process due to dementia (progressive mental disorder characterized by failing memory, confusion.). The care plan directed staff to allow the resident to vent her feelings when she became frustrated and listen attentively. The care plan documented staff assisted the resident with her collection of personal items that she liked and brought them to the commons area as needed. R168's Medical Power of Attorney, dated [DATE], documented R168 designated her family member to be in charge of medical decisions if the resident became unable to make her own decisions. Review of R168's signed Physician orders, dated [DATE] documented the resident a Full Code status (a person will allow all interventions needed to get their heart started). The Social Services Note, dated [DATE] at 08:28 AM, recorded staff questioned the resident to see how she felt (as her family member (DPOA for healthcare) had recently died), she replied, ok. SSD brought up the family member's death, but the resident did not dwell on the subject and quickly moved on to another. The family never came and told the resident what happened to the family member that died . The Nurse's Note, dated [DATE] at 02:47 PM, recorded the facility contacted Physician HH's office regarding an order to discuss Hospice with resident, as the resident's physician was out of the office for the week. The note recorded the resident had declined since returning from the hospital, was not eating, drinking, or acting her normal. The note recorded the resident now received oxygen continuously where she was not prior to being hospitalized . The note recorded the resident had no family or guardian to make any decisions for her. Administrative Nurse E, Consultant HH, and this nurse discussed that Hospice might be the way to go for the resident. Depending on the order from the physician was how the facility would proceed with whether to place the resident on Hospice or not. The Nurse's Note, dated [DATE] at 01:38 PM, recorded the physician prescribed R168's weight loss as unavoidable due to recent decline in condition and hospice admission. The note recorded the resident did not have a DPOA, her family member was her DPOA and he recently passed away. Review of R168's Electronic Medical Record (EMR) lacked documentation staff attempted to contact other family members after the resident's DPOA passed away. The Nurse's Note, dated [DATE] at 03:30 AM, recorded the facility contacted Emergency Medical Services (EMS) to transport the resident to the hospital. The note recorded the hospital contacted the facility and requested the resident's [DIAGNOSES REDACTED]. The note recorded the facility gave the resident's physician the number for hospice since both the physician and nursing facility felt that due to resident not having any other family listed, hospice should be there to assist. R168's EMR lacked an Advanced Directive to designate a responsible party or DPOA for healthcare or finances after the resident's family member died . On [DATE] at 02:00 PM, Administrative Staff A verified the resident did not have a DPOA or designated representative for healthcare or financial decisions and lacked an Advanced Directive. Administrative Staff A verified the resident's cognition declined and Social Service Designee called the state to find out what to do or get a court appointed guardian and was told since the resident was already admitted to the facility they were unable to get a court appointed guardian. Administrative Staff A verified the facility had a meeting with the Administrator, Director of Nursing, Social Service Designee, and the Hospice Nurse, and it was decided since the facility knew R168 they would make her healthcare decisions for her. (The EMR lacked documentation of this meeting) On [DATE] at 02:40 PM, Administrative Nurse D verified the resident did not have a designated representative for her medical or financial management and did not have a signed DPOA form, or signed code status form in the resident's electronic or paper healthcare records. The facility's Advising Surrogate or Representative of Resident's Rights and Responsibilities policy, dated [DATE], documented should a resident be declared incompetent or determined to be medically incapable of understanding his or her rights, the resident's surrogate and/or representative will be advised of the resident's rights and responsibilities. 1. Should a resident be declared incompetent in accordance with the state's law or be determined by an appropriately documented assessment to be medically incapable of understanding his or her rights, the resident's surrogate, representative, or other individual will be advised of the resident's rights and responsibilities, in accordance with state laws regarding substitute decision making. 2. The surrogate or representative (sponsor) must acknowledge, in writing, that an oral explanation of the resident's wishes and responsibilities has been made and that he or she also receive a written copy of such material. 3. A copy of the signed acknowledgement must be filed in the resident's medical record. 4. Our facility will seek a health care decision, or any other decision or authorization, from a surrogate or representative (sponsor) only when the resident is determined to be incompetent in accordance with state law. 5. Regardless of the assignment of rights, the resident's expressed wishes will be followed to the highest degree practical. The facility failed to attempt to provide Resident (R) 168 the right to designate a representative or DPOA before her cognition declined, placing the resident at risk for inability to make informed healthcare decisions.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents with one reviewed for accommodation of needs. Based on observation, record review, and interview, the facility failed to provide Resident (R) 166 transportation from the emergency room back to the facility. Findings included: - R166's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS recorded the resident required limited staff assistance with transfers and ambulated without an assistive device. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 04/25/20, directed staff to assist the resident with any ADL cares. The ADL Care Plan, revised 04/25/20, directed staff to assist the resident as needed. The Nurses Note, dated 04/20/20 at 11:18 PM, recorded the facility sent the resident to the emergency room to be evaluated for change in mental status. The Nurses Note, dated 04/21/20 at 03:22 AM, recorded the emergency department called the facility at 02:00 AM and reported the resident needed transportation back to the facility. The note recorded the charge nurse contacted the facility administrator and was instructed to inform the emergency department the facility could not come and transport the resident until the morning. The Nurses Note, dated 04/21/20 at 06:39 AM, recorded the resident returned to the facility. (approximately four and half hours later) On 08/18/20 at 08:50 AM, Administrative Nurse D stated the facility had available transportation for residents during the night. Administrative Nurse D stated the facility should have transported the resident back to the facility when he needed to return. On 08/18/20 at 02:15 PM, Administrative Staff A stated if there was not staff available at the time the resident was ready to return to the facility, he/she would have to wait to be

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

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

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) transported back to the facility. The facility's Transportation policy, dated December 2008, stated the facility should help arrange transportation for residents as needed. The facility failed to accommodate R166's need for transportation, placing the resident at risk for unmet needs.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to offer Resident (R) 168 the right to formulate an Advanced Directive before her condition declined. Findings included: - R168's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS documented the resident required limited assistance of one staff with transfers, bed mobility, dressing, and personal hygiene. The Cognition Care Area Assessment (CAA), dated [DATE], documented the resident had severe cognitive impairment, inattention, and disorganized thinking. The Cognition Care Plan, dated [DATE], documented the resident had major [MEDICAL CONDITION] (MDD) and impaired cognitive function/impaired thought process due to dementia (progressive mental disorder characterized by failing memory, confusion.). The care plan directed staff to allow the resident to vent her feelings when she became frustrated and listen attentively. The care plan documented staff assisted the resident with her collection of personal items that she liked and brought them to the commons area as needed. R168's Medical Power of Attorney, dated [DATE], documented R168 designated her family member to be in charge of medical decisions if the resident became unable to make her own decisions. Review of R168's signed Physician orders, dated [DATE] documented the resident a Full Code status (a person will allow all interventions needed to get their heart started). The Social Services Note, dated [DATE] at 08:28 AM, recorded staff questioned the resident to see how she felt (as her family member (DPOA for healthcare) had recently died), she replied, ok. SSD brought up the family member's death, but the resident did not dwell on the subject and quickly moved on to another. The family never came and told the resident what happened to the family member that died . The Nurse's Note, dated [DATE] at 02:47 PM, recorded the facility contacted Physician HH's office regarding an order to discuss Hospice with resident, as the resident's physician was out of the office for the week. The note recorded the resident had declined since returning from the hospital, was not eating, drinking, or acting her normal. The note recorded the resident now received oxygen continuously where she was not prior to being hospitalized . The note recorded the resident had no family or guardian to make any decisions for her. Administrative Nurse E, Consultant HH, and this nurse discussed that Hospice might be the way to go for the resident. Depending on the order from the physician was how the facility would proceed with whether to place the resident on Hospice or not. The Nurse's Note, dated [DATE] at 01:38 PM, recorded the physician prescribed R168's weight loss as unavoidable due to recent decline in condition and hospice admission. The note recorded the resident did not have a DPOA, her family member was her DPOA and he recently passed away. Review of R168's Electronic Medical Record (EMR) lacked documentation staff attempted to contact other family members after the resident's DPOA passed away. The Nurse's Note, dated [DATE] at 03:30 AM, recorded the facility contacted Emergency Medical Services (EMS) to transport the resident to the hospital. The note recorded the hospital contacted the facility and requested the resident's [DIAGNOSES REDACTED]. The note recorded the facility gave the resident's physician the number for hospice since both the physician and nursing facility felt that due to resident not having any other family listed, hospice should be there to assist. R168's EMR lacked an Advanced Directive to designate a responsible party or DPOA for healthcare or finances after the resident's family member died . On [DATE] at 02:00 PM, Administrative Staff A verified the resident did not have a DPOA or designated representative for healthcare or financial decisions and lacked an Advanced Directive. Administrative Staff A verified the resident's cognition declined and Social Service Designee called the state to find out what to do or get a court appointed guardian and was told since the resident was already admitted to the facility they were unable to get a court appointed guardian. Administrative Staff A verified the facility had a meeting with the Administrator, Director of Nursing, Social Service Designee, and the Hospice Nurse, and it was decided since the facility knew R168 they would make her healthcare decisions for her. (The EMR lacked documentation of this meeting) On [DATE] at 02:40 PM, Administrative Nurse D verified the resident did not have a designated representative for her medical or financial management and did not have a signed DPOA form, or signed code status form in the resident's electronic or paper healthcare records. The facility's Advising Surrogate or Representative of Resident's Rights and Responsibilities policy, dated [DATE], documented should a resident be declared incompetent or determined to be medically incapable of understanding his or her rights, the resident's surrogate and/or representative will be advised of the resident's rights and responsibilities. 1. Should a resident be declared incompetent in accordance with the state's law or be determined by an appropriately documented assessment to be medically incapable of understanding his or her rights, the resident's surrogate, representative, or other individual will be advised of the resident's rights and responsibilities, in accordance with state laws regarding substitute decision making. 2. The surrogate or representative (sponsor) must acknowledge, in writing, that an oral explanation of the resident's wishes and responsibilities has been made and that he or she also receive a written copy of such material. 3. A copy of the signed acknowledgement must be filed in the resident's medical record. 4. Our facility will seek a health care decision, or any other decision or authorization, from a surrogate or representative (sponsor) only when the resident is determined to be incompetent in accordance with state law. 5. Regardless of the assignment of rights, the resident's expressed wishes will be followed to the highest degree practical. The facility failed to offer Resident (R) 168 the right to formulate an Advanced Directive before her condition declined, placing the resident at risk for unnecessary or unwanted medical treatment
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents with one reviewed for personal property. Based on observation, record review, and interview, the facility failed to document the residents personal property inventory on admission, yearly, and discharge. The facility failed to track and locate Resident (R) 168's missing diamond ring removed by the facility maintenance staff and placed in the Social Services Director's (SSD) safe. Findings included: - R168's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS documented the resident required limited assistance of one staff with transfers, bed mobility, dressing, and personal hygiene. The Accident Care Plan, dated [DATE], directed staff to assist the resident with her collection of personal items and bring items out to the commons area as needed. Review of the residents Admission Packet, dated [DATE], lacked an admission inventory sheet. The medical record lacked a yearly and discharge inventory sheet. The Social Service Note, dated [DATE] at 10:35 AM, documented the resident upset about her ring and wanted it off because it would not go over her knuckle. SSD X documented she tried to talk R168 out of having the ring removed, but R168 was adamant about it. Maintenance Staff came to SSD X's office and verified he cut R168's ring off and placed it in SSD X's locked safe. SSD X documented she received permission to have the ring go to a jeweler and put back together. The Nurse's Note, dated [DATE], documented the resident died at 10:05 PM at the facility. On [DATE] at 09:30 AM, Administrative Staff A stated the facility did not have the resident's diamond ring after an inventory was taken of the safe located in SSD's office. Administrative Staff A stated the facility did not have an admission, yearly, or dismissal inventory sheet for R168 and verified the facility policy was to hold the residents belongings for 30 days and if not claimed the facility would donate the items or keep them at the facility for residents who may need the clothing or items in the future. The facility's Personal Property policy, dated [DATE], documented the residents are permitted to retain and use personal possessions and appropriate clothing, as space permits. A representative of the admitting office would advise the resident, prior to or upon admission, as to the types and amount of personal clothing and possessions that the resident may keep in his or her room. The policy documented the residents' personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. The policy documented the facility would promptly investigate

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) any complaints of misappropriation or mistreatment of [REDACTED]. kindness respect and dignity. Federal and State laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to be free from abuse, neglect, misappropriation of property, and exploitation. Inquiries concerning resident' rights should be referred to the Social Service Director. The facility failed to document F168's personal property inventory on admission, yearly, and discharge, and failed to track and locate the resident's diamond ring, placing the resident at risk for misappropriation of property and unsolved grievances.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents with four reviewed for activities. Based on observation, record review, and interview, the facility failed to provide individual activities, designed to meet the interests, for three of four sampled residents, Resident (R) 38, R20, and R40. Findings included: - R38's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. The MDS recorded the resident required limited staff assistance with transfers, used a wheelchair for locomotion, and required staff supervision for ambulating. The MDS further recorded it was very important to the resident to have newspapers, books, magazines, music and religious activities. The Activity Care Area Assessment (CAA), dated 07/16/20, did not trigger. The revised Activity Care Plan, dated 03/16/20, recorded the facility would do in room activities until further notice due to coronavirus (a pandemic caused by severe acute respiratory syndrome). This included snacks, nails, organize the resident's room, and spontaneous activities. The Comprehensive Activity Assessment, dated 07/13/20, recorded the resident enjoyed one to one visits, exercising in room, and liked being social with everyone throughout the day. The facility lacked documentation of individualized activity participation. Review of the March-August 17, 2020 Monthly Activity Calendars recorded activities of pass ice water, cigarette run, COVID testing (a nasal swab test), and a store run. On 08/12/20 at 01:30 PM, observation revealed the resident sat in her wheelchair in her room with TV on, head down, and eyes closed. Continued observation at 02:40 PM and 04:15 PM revealed the resident continued to sit in her wheelchair in her room with TV on, head down, and eyes closed. On 08/13/20 at 09:40 AM, observation revealed the resident sat in her wheelchair by her bed with head down and eyes closed. Continued observation at 11:10 AM, 12:20 PM, and 03:15 PM revealed the resident remained in her wheelchair by her bed with head down and eyes closed. On 08/17/20 at 10:40 AM, observation revealed the resident sat in her wheelchair in her room, TV on, and resident talked to her roommate. On 08/17/20 at 11:45 AM, observation revealed the resident sat in her wheelchair and ate lunch from her bedside table in front of her. On 08/17/20 at 01:45 PM, observation revealed the resident sat in her wheelchair with head down and eyes closed. On 08/18/20 at 07:40 AM, observation revealed the resident sat in her wheelchair and ate breakfast from her bedside table in front of her. On 08/18/20 at 09:45 AM, observation revealed the resident sat in her wheelchair with head down and eyes closed. Continued observation at 01:50 PM, and 03:10 PM revealed the resident remained in her wheelchair with head down and eyes closed. On 08/12/20 at 02:30 PM, R38 stated, I am bored, there is nothing to do. On 08/17/20 at 03:15 PM, Activity Staff (AS) Z stated activity staff were not doing any group activities at that time but were trying to do one on one activities such as cleaning the residents' rooms and handing out ice cream, but AS Z had not done that recently. On 08/18/20 at 01:15 PM, Administrative Nurse D stated the facility's activities had been lacking in individualized resident needs. The facility's Activities and Social Services policy, dated December 2006, documented the resident will have the right to choose the type of activity and social events in which they wish to participate. Activities will be scheduled periodically during the day, and during evenings, weekends and holidays. The facility failed to provide R38 individualized resident activities on four of four days of the survey, placing the resident at risk for social isolation. - R20's Annual MDS, dated [DATE], recorded the resident had a BIMS score of 15, indicating intact cognition. The MDS recorded the resident required limited staff assistance with transfers and used a wheelchair for mobility. The MDS further recorded it was very important to the resident to have newspapers, books, magazines, music, religious services, and go outside. The Activity CAA, dated 05/26/20, did not trigger. The revised Activity Care Plan, dated 03/16/20, recorded the facility would do in room activities until further notice due to coronavirus. This included snacks, nails, organize the resident's room, and spontaneous activities. The Comprehensive Activity Assessment, dated 05/28/20, recorded the resident enjoyed spending time and socializing with others. The facility lacked documentation of individualized activity participation. Review of the March-August 17,2020 Monthly Activity Calendar recorded activities of pass ice water, cigarette run, COVID testing, and a store run. On 08/12/20 at 01:20 PM, observation revealed the resident lying on her left side in bed with the TV on. On 08/12/20 at 02:50 PM, observation revealed the resident lying on her left side in bed with eyes closed. Continued observation at 03:45 PM and 04:50 PM revealed the resident remained on her left side with eyes closed. On 08/13/20 at 07:40 AM, observation revealed the resident in bed, head of the bed elevated, and the resident eating breakfast from the tray on the bedside table in front of her. On 08/13/20 at 10:10 AM, observation revealed the resident in bed lying on her left side, TV on, and eyes closed. Continued observation at 01:30 PM revealed the resident remained in bed on her left side with TV on and eyes closed. On 08/13/20 at 07:40 AM, R20 stated, there is not very much going on here anymore with us having to stay in our rooms, it just makes the day so long. On 08/17/20 at 03:15 PM, AS Z stated activity staff were not doing any group activities at that time but were trying to do one on one activities such as cleaning the residents' rooms and handing out ice cream, but AS Z had not done that recently. On 08/18/20 at 01:15 PM, Administrative Nurse D verified the facility activities had been lacking in individualized resident needs. The facility's Activities and Social Services policy, dated December 2006, stated the resident will have the right to choose the type of activity and social events in which they wish to participate. Activities will be scheduled periodically during the day, as during evenings, weekends and holidays. The facility failed to provide R20 individualized resident activities, placing the resident at risk for social isolation. - R40's Admission MDS, dated [DATE], recorded the resident had moderately impaired cognition, required limited staff assistance with transfers, and able to ambulate with staff supervision. The MDS further recorded it was very important for the resident to read newspaper and go outside. The Activity CAA, dated 06/21/20, did not trigger. The Comprehensive Care Plan dated 07/01/20, recorded the resident liked to go outside and required staff to supervise the resident when he went outside, and activities including pictures and memory boxes. R40's Electronic Medical Record (EMR) lacked a Comprehensive Activity Assessment. The facility lacked documentation of individualized activity participation. Review of the resident's (Admission) June 16-August 17, 2020 Monthly activity Calendar recorded activities of pass ice water, cigarette run, COVID testing and a store run. On 08/12/20 at 01:30 PM, observation revealed the resident sat on the edge of his bed. On 08/12/20 at 03:15 PM, observation revealed the resident out in the hallway by his room, wearing a mask, staff took the resident back into his room and asked him to sit down on the bed. On 08/12/20 at 04:20 PM, observation revealed the resident sat on the edge of his bed with eyes closed. On 08/13/20 at 07:45 AM, observation revealed the resident sat on the edge of his bed and ate breakfast from the bedside table in front of him. Continued observation at 09:30 AM, 10:45 AM and 01:50 PM revealed the resident sat on the edge of his bed with head down. On 08/17/20 at 03:15 PM, AS Z stated activity staff were not doing any group activities at that time but were trying to do one on one activities such as cleaning the residents' rooms and handing out ice cream, but AS Z had not documented competition of any activities or one of one. On 08/18/20 at 01:15 PM, Administrative Nurse D verified the facility activities had been lacking in individualized resident needs. The facility's Activities and Social Services policy, dated December 2006, stated the resident will have the right to choose the type of activity and social events in which they wish to participate. Activities will be scheduled periodically during the day, as during evenings, weekends and holidays. The facility failed to provide R40 individualized resident activities, placing the resident at risk for social isolation.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents with five reviewed for nutrition. Based on observation, record review, and interview, the facility failed to develop and implement effective nutritional interventions for one of three sampled residents, Resident (R) 8, who had a weight loss of 20 pounds (lbs) in six months. Findings included: - R8's Physician order [REDACTED]. The Significant Change Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. The MDS recorded the resident required supervision with oversight, encouragement, or cueing with eating. The Nutrition Care Area Assessment (CAA), dated 06/11/20, did not trigger. The Nutrition Care Pan, dated 05/28/20, documented the resident had potential nutritional problems due to decline in abilities, cognitive deficit, and at risk for weight loss. The care plan directed staff to observe the resident for pocketing, choking, coughing, drooling, holding food in his mouth, and refusing

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) to eat. The care plan instructed staff to observe and report to the physician significant weight loss greater than 10% in six months, and registered dietician to evaluate and make diet changes and recommendations. R8's Vital Signs documented the following weights: 01/06/20 - 168.0 lbs. 02/11/20 - 164.4 lbs. 03/10/20 - 162.8 lbs. 04/08/20 - 163.2 lbs. 05/08/20 - 160.0 lbs. 06/17/20 - 151.6 lbs. 07/14/20 - 147.8 lbs. (loss of 20.2 lbs., or 12.02% in six months) The Physician Order, dated 07/23/20, directed staff to administer the resident a regular diet, regular texture, and regular consistency. The Dietary/Nutritional Note, dated 07/09/20, documented the resident had weight loss, average meal intake from 50% to 100%, received a weight stimulant ([MEDICATION NAME]), but lacked any recommendations. On 08/18/20 at 02:40 PM, Administrative Nurse D stated the resident had a weight loss of 20.2 lbs in six months, planned to contact the Registered Dietician to reassess the resident's nutritional needs. The facility's Weight Assessment and Intervention policy, dated September 2018, documented the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for the residents. The nursing staff would measure resident's weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Any weight change of 5 percent or more since the last weight assessment would be retaken the next day for confirmation. If the weight is verified, nursing would immediately notify the Dietician in writing. Verbal notification must be confirmed in writing. The Dietician would respond within 24 hours of receipt of written notification. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; greater than 5% is severe 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. 6 months- 10% weight loss is significant; greater than 10 % is severe. The multidisciplinary team would determine the residents target weight range, approximate calorie, protein, and other nutritional needs compared with the resident's current intake, and the relationship between current medical condition or clinical situation and recent fluctuations in weight and whether and to what extent weight stabilization or improvement can be anticipated. The facility failed to provide R8 adequate nutritional interventions, placing the resident at risk for continued weight loss and inadequate nutrition.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 168 medically related Social Services to assist the resident in finding and designating a responsible party to help with financial and healthcare decisions. Findings included: - R168's Quarterly Minimum Data Set ((MDS) dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS documented the resident required limited assistance of one staff with transfers, bed mobility, dressing, and personal hygiene. The Cognition Care Area Assessment (CAA), dated 09/30/19, documented the resident had severe impairment, inattention, and disorganized thinking. The Cognitive Care Plan, dated 01/10/20, documented the resident had major [MEDICAL CONDITION] (MDD) and impaired cognitive function/thought process due to dementia. The care plan directed staff to allow the resident to vent her feelings when she became frustrated and listen attentively. The care plan documented staff assisted the resident with her collection of personal items that she liked and brought them to the commons area as needed. R168's Medical Power of Attorney, dated 12/15/15, documented she designated her family member to be in charge of medical decisions if R168 became unable to make her own decisions. The Social Service Admission Assessment, dated 03/29/16, documented the resident transferred to the facility from another facility. The Advanced Directive from the hospital discharge paperwork documented the resident's code status as Do Not Resuscitate (DNR), Advanced Care Plan Materials provided, and discussed on 01/01/2016 with the resident's expected stay in the facility as indefinite. The Social Service Note, dated 12/17/15 at 09:59 AM, recorded the facility admitted the resident from another facility with increased confusion and a DNR status. The Social Service Note, dated 04/28/16 at 11:57 AM, recorded the resident confused today, wanted to leave the facility, and did not remember she lived at another facility prior to her current admission. The Social Service Note, dated 06/23/17 at 11:48 AM, recorded staff completed the resident's BIMS assessment and documented a scored of five, indicating severely impaired cognition. The Social Service Note, dated 03/06/18 at 11:10 AM, recorded staff informed the resident her Medical Power of Attorney passed away the previous day. The Social Service Note, dated 05/09/18, recorded staff completed the resident's BIMS assessment and documented a score of four, indicating severely impaired cognition. The Social Service Note, dated 03/07/19 at 03:16 PM, recorded staff completed the resident's BIMS assessment and documented a score of six, indicating severely impaired cognition. The Social Service Note, dated 05/29/19, documented the facility spoke with the Ombudsman for guidance for the resident regarding decision making, because the resident was unable to make her own decisions and did not have family to help make decisions. The facility was concerned the resident's primary care physician was trying to discontinue a medication Hospice and the facility nurse felt the resident needed to be comfortable. The Ombudsman voiced to the SSD that since the resident did not have any family to help make decisions and facility staff knew her best, that facility staff needed to do what was right for the resident. The Social Service Note, dated 09/11/19 at 04:48 PM, recorded staff completed the resident's BIMS assessment and documented a score of five, indicating severely impaired cognition. The Social Service Note, dated 12/10/19 at 04:27 PM, documented staff completed the residents quarterly BIMS, but lacked a score. The notes documented the resident remained a DNR and continued Hospice services. The Social Service Notes and Electronic Health Records lacked documentation of discussion with the resident and/or DPOA regarding her designated or alternate agent for medical and financial decision regarding the resident's care and code status. On 08/20/20 at 09:10 AM, Administrative Nurse D stated the resident's medical record lacked a signed DNR form and would contact the Primary Care physician to see if they had documentation in their medical records and stated, I don't know how many balls could have been dropped on one person. Upon request, the facility failed to provide a Social Services policy. The facility failed to provide R168 social service support and guidance after the resident's medical DPOA passed away and her cognition declined requiring assistance with medical decisions, placing the resident at risk for inability to make an informed decision.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents with six reviewed for unnecessary medications. Based on observations, record review, and interview, the facility failed to adequately monitor and appropriately assess blood sugars, recheck blood sugars out of normal range, and notify the physician, for one of six sampled residents, Resident (R) 52. Findings included: - R52's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS recorded R52 required extensive staff assistance with Activities of Daily Living (ADLs), diabetes mellitus (when the body cannot use glucose, not enough insulin produced, or the body cannot respond to insulin), and received insulin (hormone that regulates blood sugar levels) injections seven days a week. The Diabetes Care Plan, dated 08/04/20, instructed staff to check R52's fasting blood sugar as physician ordered, check R52's blood sugar in the morning and evening, and administer diabetic medications as physician ordered. The care plan further directed staff to observe, document, and report signs or symptoms of low (increased heart rate, confusion) or high blood sugars (increased thirst and appetite, fatigue), and notify the physician if blood sugar greater than 350 milligrams/deciliter (mg/dl). The physician's orders [REDACTED]. Review of R52's June-August 2020 Medication Administration Record [REDACTED]. R52's June 1-30, 2020 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters, lacked nurse assessment, or physician notification: 06/20/20 at 05:46 PM - 354 mg/dl 06/24/20 at 05:54 PM - 359 mg/dl 06/24/20 at 05:55 PM - 362 mg/dl R52's July 1-31, 2020 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters, lacked nurse assessment, or physician notification: 07/08/20 at 04:52 PM - 404 mg/dl 07/09/20 at 05:14 PM - 575 mg/dl 07/10/20 at 05:13 PM - 402 mg/dl 07/12/20 at 04:45 PM - 429 mg/dl 07/22/20 at 04:47 PM - 370 mg/dl 07/29/20 at 05:35 PM - 353 mg/dl 07/30/20 at 05:19 PM - 377 mg/dl R52's August 1-17, 2020 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters, lacked nurse assessment, or physician notification: 08/09/20 at 05:15 PM - 352 mg/dl 08/10/20 at 05:34 PM - 427 mg/dl 08/11/20 at 04:50 PM - 353 mg/dl On 08/13/20 at 11:31 AM, observation revealed staff monitored the resident as he independently ate and drank his meal without difficulty. Observation revealed the resident alert with no behaviors and no signs of pain. On 08/18/20 at 08:54 AM, Licensed Nurse (LN) G stated she was not aware of any blood sugar parameters for R52. LN G stated low blood sugar protocol was below 70 mg/dl and his doctor usually did not give parameters. LN G stated if there were no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175185	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SMOKY HILL REHABILITATION CENTER	**1007 JOHNSTOWN AVENUE SALINA, KS 67401**

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

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) parameters to use nursing judgement. On 08/18/20 at 01:24 PM, Administrative Nurse D stated the parameters for high blood sugars were set by the resident's physician. Administrative Nurse D stated the resident had multiple blood sugars over 300 mg/dl and one over 500 mg/dl. Administrative Nurse D stated the physician was not notified due to no parameters, was unable to find any parameters for this resident, and unaware if the facility had a diabetes policy. Upon request, the facility was unable to provide a blood sugar monitoring policy. The facility failed to adequately monitor and appropriately assess R52's blood sugars, recheck out of normal range blood sugars, and notify the physician, placing the resident at risk for untreated high and low blood sugars.
F 0801 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 66 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full time Certified Dietary Manager for the 66 residents who resided in the facility and received their meals from the facility kitchen. Findings included: - On 08/12/20 at 08:45 AM, observation during initial kitchen tour revealed dietary staff served the breakfast meal to the residents. On 08/12/20 at 11:40 AM, observation revealed the posted noon meal menu included Italian sausage, seasoned spinach, garlic and [MEDICATION NAME] red potatoes, lemon bar and drink of choice. Residents could choose what they wanted prior to the meal being served or they could choose from an alternate menu of grilled cheese sandwich, chicken and noodle soup, chef or side salad, grilled meat and cheese sandwich. On 08/12/2020 at 11:50 AM, Dietary Staff (DS) BB stated she was not a Certified Dietary Manager. DS BB stated she had worked as the dietary manager for a year and was enrolled in the dietary manger program. DS BB verified one resident received a pureed diet and twelve residents received a mechanical soft diet. On 08/12/2020 at 04:45 PM, Administrative Staff A verified DS BB was not certified and was currently enrolled in a certified dietary manager online course. The facility's Food Service Director policy, dated December 2008, documented the Certified Dietary Manager would be a qualified supervisor licensed by the state and is knowledgeable and trained in food procurement storage, handling, preparation, and delivery. The Food Service Manager is responsible for the daily functions of the Food services department in accordance with the facility's department policies and procedures. Additional responsibilities of the Food Service Manager include supervision, training, assisting the dietician and the nursing service department in selecting residents who may be fed by feeding assistance. The facility failed to employ a full time Certified Dietary Manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 66 residents in the facility who received their meals from the facility kitchen, placing the residents at risk for inadequate nutrition.
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 66 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide a safe and sanitary environment to help prevent the potential development and transmission of disease and infection for the 66 residents that resided in the facility. Findings included: - On 08/17/20 at 10:50 AM, observation revealed Resident (R) 45 propelled her wheelchair from the 300 Hall to the dining/living room hydration area, placed a large plastic refillable cup against the metal ice dispensing surface, dispensed ice into the cup, and propelled herself down the 300 Hall. On 08/18/20 at 11:55 AM, observation revealed Certified Nurse Aide (CNA) N removed two plastic refillable cups from residents' rooms on the 300 Hall and placed the lip surface of the cups against the metal bar on the ice machine, filled them with water, then returned the plastic cups to the residents' rooms. On 08/18/20 at 02:40 PM, Administrative Nurse D stated the resident should not fill the ice cups herself and she had been instructed numerous times to ask staff for assistance. Administrative Nurse D verified staff should not refill residents' used cups at the ice machine, should obtain a new clean cup each time, or fill the cup with ice from a clean cup and place in the soiled cup. The facility's Serving Drinking Water policy, dated October 2017, documented the facility would provide the resident with a fresh supply of drinking water and to provide adequate fluids for the residents. The policy documented the staff would complete the following steps: 1. Fill the ice chest with ice. Cover the chest. 2. Roll the cart to the outside entrance of the resident's room. 3. Go to the resident's bedside stand and pick up the water pitcher. 4. Take the water pitcher into the bathroom. Empty the contents into the commode. Flush the commode. 5. Rinse the water pitcher with tap water. Pour the water down the sink 6. Fill the water pitcher one-half full of tap water. 7. Unless the resident is in isolation, take the water pitcher to the ice cart outside the room. Fill the pitcher with ice. Do not let the ice scoop touch the water pitcher. 8. Return the water pitcher to the resident's bedside stand. 9. Wipe the bedside stand with a clean paper towel. Discard used paper cups, paper towels and other disposable items into designated container. 10. Offer the resident a fresh cup of water. 11. Place the water pitcher and cup within easy reach of the resident. The facility failed to maintain a safe, and sanitary environment to help prevent the development and transmission of diseases and infection for the 66 residents that resided in the facility, placing the residents at risk for infection.