STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00168817, #KS00168097, #KS00168788, #KS0016996, and #KS00168587. This 2567 was electronically sent to the facility on 02/09/2022.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents. Based on interview and record review the facility failed to provide scheduled baths in accordance with the resident's planned shower schedule to ensure necessary services to maintain good personal hygiene, for 19 dependent residents including; (R2, R3, R4, R5, R6, R7, R9, R10, R11, R 2, R 3, R14, R15, R16, R17, R18, R19, R20, R21, and R22). Findings Included: - On 01/25/22 at 08:34 AM, resident (R)5 stated the facility needed more staff. She was not getting a shower every other day like she preferred. She reported she was lucky to get one bath a week. R5 reported she was dependent on staff to raise her legs and she had told staff she wanted to be bathed more frequently but nothing changed.	F 677		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 1	F 677		

On 01/25/22 at 9:05 AM, R6 stated the facility needed more staff. She sometimes only received a bath one time a week if then. She stated she was dependent on staff for her care because she had a crippled foot and could not shower independently.

On 01/25/22 at 10:47AM, Certified Nurse Aide (CNA) M stated the residents should receive a minimum of two baths/showers a week. If a resident wanted more showers/baths it should be documented in the care plan. The residents do not always get care they need such as bathing due to not having enough staff.

On 01/25/22 at 02:25 PM, CNA N reported the facility had a bathing schedule for the residents. Staff scheduled the residents bathing for the day and evening shifts twice a week during the day or evenings according to the residents' preference. Bathing may include one actual shower and one full bed bath. Staff should document baths and the type given in the EMR. If the staff offered the resident a bath and the resident refused that should be documented in the EMR as well. Refusals should be documented as a refusal.

On 01/25/22 at 03:50PM, Administrative Nurse D stated in December 2021, she received a complaint from R3's family member related to her not receiving her baths. The facility completed an audit which indicated baths were not provided as scheduled in accordance with the residents' preferences. She reported the facility hired additional staff and continued to hire staff to facilitate the resident's receipt of personal hygiene care. The facility staff revised the bathing schedule in the prior week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 2	F 677		

Review of the facility's bathing "ADL Verification Worksheets," (Spreadsheet which documented offered bathing, type of bath, and refusals), dated 12/25/21 through 1/25/22, revealed the facility failed to provide scheduled baths in accordance with the residents' preferences for 19 dependent residents (R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R15, R16, R17, R18, R19, R20, R21, and R22).

On 1/35/22 at 04:40PM, Administrative Nurse D Confirmed the current findings related to the lack of bathing for the 19 residents as noted above. Additionally, she verified the following resident hygiene concerns:

1. R5 admitted 1/5/22 and staff provided baths for her on 01/7/22 and 01/13/22. She received two bath/showers in 20 days.

2. Staff provided baths for R3 on 12/31/ 21, 01/07/22, 01/17/22, and 01/21/22. She received four bath/showers in 30 days.

3. Staff provided baths for R2 on 01/05/22, 01/07/22, and 01/12/22. She received three bath/showers in 30 days.

4. Staff provided baths for R9 on 12/27/21, 12/28/21, 01/10/22, and 01/17/22. She received four showers/baths in 30 days.

Administrative Nurse D stated the residents should receive a minimum of two baths and/or showers a week unless otherwise specified. She confirmed the residents did not receive baths/showers in accordance with the schedule or preferences of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 3 The facility lacked a policy to address the provision of staff assistance to ensure scheduled bathing/showers in accordance with resident's preferences. The facility failed to provide scheduled baths in accordance with the resident's planned shower schedule to ensure necessary services to maintain good personal hygiene, for 19 dependent residents.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 46 residents with eight residents sampled for review which included one resident (R)7 reviewed for skin condition. Based on interviews and record review the facility failed to complete a skin assessment when they found a 23 by 4 centimeters bruise on her arm, the day after staff found the resident on the floor to ensure resolution of the bruising without complications. Findings included: - Review of the resident's (R)7's undated "Physician Orders," revealed diagnoses which	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

included, heart failure, hypertension (low blood pressure), urinary tract infection, seizure disorder, hypothyroidism (low functioning of thyroid gland which effects metabolism), asthma, acute respiratory failure, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cardiomegaly, pleural effusion (build-up of fluid between the tissues that line the lungs and the chest), and age related physical debility.

The Admission "Minimum Data Set" (MDS) dated 10/26/21, documentation included the "Brief Interview for Mental Status" (BIMS) score of 13, which indicated cognitively intact. The resident required extensive assistance of two staff with bed mobility, transfers, walking, toilet use, and dressing. Her balance during transition was not steady and she was only able to stabilize with staff assistance. She had limitation in range of motion on one side of her lower extremities and used a wheelchair (w/c) and walker as assistive mobility devices. She had not fallen prior to admission and/or since admission.

The "Quarterly MDS," dated 12/08/21, documented the following changes, BIMS score of 15, indicating improved cognition.

The "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) and "Fall" CAA, dated 11/05/21, respective documentation, included the resident required assistance with Activities of Daily Living" (ADL) secondary to impaired balance and transition during transfers, and functional impairment in activity. Contributing factors included generalized weakness, and decreased safety awareness. Her risk factors included further ADL decline.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

The care plan (CP), dated 11/3/2021, directed staff that the resident was at risk for bruising and staff were instructed to contact the physician with concerns.

On 12/31/21 at 4:47AM, Nurses' Notes revealed the nurse went to answer the resident's call light and found the resident on her hands and knees crawling toward her bathroom. When this nurse asked resident why she was on the floor the resident stated that she was taking herself to the bathroom. The resident did not fall at any time. Resident purposely got down from her bed. She was crawling on her hands and knees to the bathroom. The staff used a full body lift with two staff to assist the resident from the floor to her bed. The staff then used a sit-to-stand lift, with two staff assistance, to transfer the resident from her bed to the toilet and to return the resident to the bed after toileting. The medical record lacked address of a completed skin assessment to determine the existence of skin condition/injury.

On 01/01/22 at 11:08AM, Nurses' Notes included the staff used the Sit to stand lift with two staff for assistance with transfers. Her skin was cool and dry to touch. The medical record lacked address of a completed skin assessment to determine the existence of skin condition/injury.

On 01/2/22 at 11:25AM, the Nurses' Notes documentation noted the resident with bruising on her right arm, where she crawled on the floor the previous day and leaned on her metal bed frame. The medical record lacked address of a completed skin assessment to determine the extent of the bruising or injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684		

On 01/02/22 at 01:10PM, the Nurses' Notes included the staff noted no skin concerns on the resident.

On 01/09/22 at 04:19PM, the Nurses' Notes documented the resident's weekly scheduled skin assessment. The writer observed the resident with purple bruising to her left posterior upper arm spanning 23.0 centimeters (cm) by 4.0 cm. The resident stated she fell out of her bed last weekend. The nurse documented a CNA informed her that on 01/01/22 another nurse stated the resident was on the floor and staff members had assisted her up with a gait belt. A standing order was initiated to monitor the bruise and a fax was sent to the physician. This was the first documentation of a completed skin assessment and communication with the physician regarding the resident crawling on the floor on 12/31/21 and 01/01/22 and of the bruising first identified on 01/02/22.

On 01/10/22 at 11:57PM, Nurses' Notes documented the resident was sent to the hospital for an unrelated change in condition.

On 01/24/22 at 01:36 PM, Consultant Staff GG, reported the physician was not made aware of the resident's falls (crawling on the floor), nor the large bruise on her arm until she was seen by the physician in the emergency room for her changing respiratory status on 01/10/22 (nine to 10 days after the events.)

On 01/25/22 at 11:26 AM, CNA M stated the resident required a sit to stand lift with two staff to assist for a transfer. She reported the protocol for staff to follow if they found a resident on the floor included immediate notification of the nurse. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7	F 684		

nurse should assess for pain, movement, skin, and neuro checks to determine if the resident sustained an injury. The nurse should provide the staff with directions regarding further care of the resident and make notifications of the event to the family/representative and the physician.

On 01/25/22 at 02:17 PM, Certified Nurse Aide (CNA) N and CNA O reported if someone falls or is found on the floor, staff should immediately notify the nurse. The nurse should assess the resident's skin, range of motion and pain to determine if there is any injury. The staff should not move the resident until the nurse assesses the resident and then gives permission to move the resident. The nurse should notify the physician, family, and provide instructions for continued care. She should implement a new immediate intervention to prevent further falls and/or injury. Staff should complete witness statements related to the resident's actions leading up to the fall or being found on the floor.

On 01/27/22 at 10:50 PM, Licensed Nurse (LN) H stated that residents found on the floor should be assessed by the nurse prior to staff moving the resident to ensure there was no injury. The assessment should include range of motion and skin condition. LN H stated she did not consider the event a fall because the resident stated she lowered herself to the floor to go to the bathroom. She reported she did not see any bruising until the next day. She failed to complete a complete skin assessment with measurements or open an event report in the medical record as she should have done at that time. LN H stated she did not notify the physician nor the family of the event or the bruise. Bruising should be measured and monitored to prevent complications. Injuries

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 should be reported to the physician and family. On 01/25/22 at 02:49PM, Administrative Nurse D stated staff should document when residents are found on the floor. Documentation should include assessments to include skin assessments as well as notification of family and physician of any skin issues such as bruising when noted. Skin assessment should include measurements to ensure monitoring to determine complications. She confirmed the findings as noted above. The facility failed to provide a policy to address monitoring of non-pressure related skin conditions. The facility failed to complete an accurate skin assessment with continued follow-up monitoring, when they found the 23 by 4 cm bruise on the resident's arm to ensure resolution.	F 684		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 9	F 725		

types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 46 residents. Based on Interview and record review the facility failed to provide adequate sufficient nursing staff to provide nursing related services of adequate bathing/hygiene, to maintain the highest practicable physical, mental, and psychosocial well-being for at least 19 residents, including; (R2, R3, R4, R5, R6, R7, R9, R10, R11, R 2, R 3, R14, R15, R16, R17, R18, R19, R20, R21, and R22).

Findings Included:

- On 01/25/22 at 08:34 AM, resident (R)5, stated the facility needed more staff. She was not getting a shower every other day like she preferred. She reported she was lucky to get one bath a week. R5 reported she was dependent on staff to raise her legs and she had told staff she wanted to be bathed more frequently but nothing changed. Additionally, she stated she needed assistance with going to the bathroom and has waited on the toilet for an hour waiting for assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 10	F 725		

On 01/25/22 at 9:05 AM, R6 stated the facility needed more staff. She sometimes only received a bath one time a week if then. She stated she was dependent on staff for her care because she had a crippled foot and could not shower independently. Additionally, she reported that she had waited as long as 30 minutes for her call light to get answered. She needed help with getting in and out of the bed and going to the bathroom. The resident further explained that the staff do what they can they just need more.

On 01/25/22 at 10:47AM, Certified Nurse Aide (CNA) M stated the residents should receive a minimum of two baths/showers a week. If a resident wanted more showers/baths it should be documented in the care plan. The residents do not always get care they need such as bathing due to not having enough staff. A lot of days the staff go home frustrated because the residents do not get the care they need. She stated she gets frustrated when call lights are going and she cannot get to them in a timely manner due to staff shortages. CNA M further stated that working together was a big issue.

On 01/25/22 at 02:25 PM, CNA N reported the facility had a bathing schedule for residents. Staff scheduled the residents bathing for the day and evening shifts twice a week during the day or evenings according to the residents' preference. Bathing may include one actual shower and one full bed bath. Staff should document baths and the type given in the EMR. If the staff offered the resident a bath and the resident refused that should be documented in the EMR as well. Refusals should be documented as a refusal.

On 01/25/22 at 03:50PM, Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 11	F 725		

stated in December 2021, she received a complaint from resident 3's family member related to her not receiving her baths. The facility completed an audit which indicated baths were not provided as scheduled in accordance with the residents' preferences and care [lan. She reported the facility hired additional staff and continued to hire staff to facilitate the resident's receipt of personal hygiene care. She stated the facility's difficulty with hiring and retaining staff had increased with the pandemic and increasing acuity of the residents.

Review of the facility's bathing "ADL Verification Worksheets," (Spreadsheet which documented offered an bathing, type of bath, and refusals), dated 12/25/21 through 1/25/22, revealed the facility failed to provide scheduled baths in accordance with the residents' preferences for 19 dependent residents (R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R 4, R15, R16, R17, R18, R19, R20, R21, and R22).

On 1/35/22 at 04:40PM, Administrative Nurse D Confirmed the current findings related to the lack of bathing for the residents as noted above. She stated the staffing challenges were an obstacle to providing resident care. Additionally, she verified the following resident hygiene concerns:

1. R5 admitted 1/5/22 and staff provided baths to her on 01/7/22 and 01/13/22. She received two bath/showers in 20 days.

2. Staff provided baths for R3 on 12/31/ 21, 01/07/22, 01/17/22, and 01/21/22. She received four bath/showers in 30 days.

3. Staff provided baths for R2 on 01/05/22,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 12	F 725		

01/07/22, and 01/12/22. She received three bath/showers in 30 days.

4. Staff provided baths for R9 on 12/27/21, 12/28/21, 01/10/22, and 01/17/22. She received four showers/baths in 30 days.

Administrative Nurse D stated the residents should receive a minimum of two baths and/or showers a week unless otherwise specified. She confirmed the residents did not receive baths/showers in accordance with the schedule or preferences of the residents.

The facility lacked a policy to address the provision of adequate staffing to ensure scheduled bathing/showers in accordance with resident's preferences.

The facility failed to provide adequate sufficient nursing staff to provide nursing related services of adequate bathing/hygiene, to maintain the highest practicable physical, mental, and psychosocial well-being for at least these 19 residents.