December 2025 Kansas Survey Findings
Normal Font-Health Survey
Italics= Complaint Survey
Findings in Red=G+ Scope & Severity
Findings in Green from State Regulations
SS=Scope & Severity; LN=Licensed Nurse
TX=treatment; Dx=Diagnosis; Fx=Fracture
CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist
PU=Pressure Ulcer; ID=identify; Hx=History; MDD=Major Depressive Disorder

October 2025
November 2025

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to preserve 1 resident's dignity when staff failed to ensure that resident's catheter bag was covered with a catheter dignity bag

- On 09/29/25 at 07:15 AM, resident sat in recliner in room; resident's catheter bag rested on floor, & no dignity bag covered bag. Urine was visible in urine collection bag

NE: SS=D: Failed to provide a dignified care environment for 2 residents

- Incident Report #1090" completed on 09/23/25 indicated CNA entered1 resident's room on 09/18/25. The report indicated resident asked CNA why they were in room. Resident stated in the report, CNA replied, "It's none of your fucking business." The report indicated CNA was immediately suspended (pending investigation). The report indicated resident's roommate witnessed incident but denied that CNA used abusive language. The report indicated that CNA admitted to saying, "it's none of your business" upon talking to both residents. The report indicated CNA was provided training r/t resident rights, communication, and abuse prevention
- On 09/22/25 at 08:33 AM, resident sat at breakfast table with peers. CNA stood over resident and gave resident a spoonful of ground meat. Resident's bare abdomen & right side visible to peers

NE: SS=D: Failed to ensure dignified care environment for 1 resident when staff spoke to resident in disrespectful manner when resident asked for assistance

- Monthly Grievance Logs indicated resident filed grievance on 09/10/25 r/t CNA's conduct. A review of the grievance report revealed it was documented as a staff concern. The grievance indicated CNA was repeatedly rude to resident. The grievance indicated that CNA told resident that all direct care staff did not like resident because resident had to go to the bathroom too much. The report indicated CNA denied making the comment, but indicated CNA was short with resident & had not provided good customer service. The report indicated CNA was given corrective action & instructed not to provide care for resident. The note indicated resident felt safe. The report indicated resident's family felt safe with resolution on 09/12/25. On 09/30/25 at 01:20 PM, members of the facility's resident council indicated resident struggled with being bullied by CNA. The council report concerns that facility did not talk to resident about how the incident affected resident

F554 Resident Self-Administration of Meds-Clinically Appropriate

NE: SS=D: Failed to ensure safe & appropriate self-administration of medication for 1 resident

- CP lacked documentation of self-administration of medication; record lacked assessment for self-administration; observed resident in bed with plastic med cup of unidentified pills on beside table, arm's length away from bed;

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive

NE: SS=D (Past noncompliance): Failed to follow 1 resident's chosen advanced directives r/t resident's DNR wishes for CPR

- Resident's CP initiated 08/29/25 indicated resident's advance directives listed resident as a DNR on 08/29/25. The plan instructed staff to honor resident's advance directives & end-of-life decision. Resident's EMR under "Miscellaneous" revealed a "Do Not Resuscitate Directive" signed by resident & medical provider on 08/29/25. Resident's EMR under "Physicians Orders" revealed resident had a DNR order started on 08/29/25. Incident Report completed on 9-8-25 indicated resident was found unresponsive by staff on 09/07/25 at 04:55 PM. The report indicated that staff noted nursing report sheet indicated resident was a full code. The report revealed staff began CPR on resident w/o verifying resident's advanced directives in her EMR. At 04:57 PM, EMS arrived & took over CPR. The report indicated resident's pulse returned, and resident was transported to an acute medical facility for treatment
    - Plan of Removal:
        - Completed audit of current residents to verify appropriate code status for each resident
        - Completed staff education for all direct care staff r/t advance directives & where appropriate place to find code status for each resident
        - Facility will completed 5 staff interviews weekly to ensure staff knowledge of advance directives starting
        - Facility will complete "practice codes" weekly on alternating shifts to ensure staff knowledge for 6 weeks
        - QAPI team reviewed results of audits & interviews to ensure ongoing compliance

F582 Medicaid/Medicare Coverage/Liability Notice

NW: SS=D: Failed to provide CMS Form 10123, "Advanced Beneficiary Notice" (ABN), to resident/representative for 1 resident

- Facility lacked documentation staff provided 1 resident/representative CMS form 10123, which had information on whether resident wanted to appeal decision, when resident's skilled services ended on 06/05/25

F600 Free from Abuse & Neglect

NE: SS=D (Past Noncompliance): Failed to prevent staff-to-resident verbal & emotional abuse of 1 resident

- Incident Report completed on 08/12/25 indicated CNA observed another CNA use abusive language towards resident. The report indicated that on 08/12/25, around 05:00 PM, CNA told resident "Let go of the bear dummy," as CNA took resident's bear away from resident against resident's wishes. The report indicated CNA then told resident, "You ripped it, dummy," after pulling it away from resident. The report indicated that other CNA reported the incident, and CNA was immediately suspended & terminated. The report indicated resident was immediately assessed with no injury or change in mood. The report indicated resident's bear was resident's coping mechanism for calming down
    - Plan of Removal: Facility identified, implemented, & completed the following corrective actions r/t incident:
        - The facility screened all affected residents on 08/12/25.
        - The facility assessed resident for psychosocial trauma from the incident on 08/12/25.
        - CNA was immediately suspended, terminated, & reported to the investigative agencies on 08/12/25.
        - All staff educated on Abuse, Neglect, & Exploitation on 08/30/25.
        - The facility will monitor & provide ongoing education through the Quality Assurance and Performance Improvement program (QAPI) team

NE: SS=J (Past Noncompliance): Failed to ensure 2 other cognitively impaired residents remained free from resident-to-resident physical abuse by resident

- *On 09/30/25 at 07:55 AM, CNA left the facility dining area unsupervised to assist another staff member. When CNA returned to dining area, CNA observed other resident with blood on face while resident (who had a history of wandering into resident rooms and behaviors including wanting to fight) stood nearby with blood on resident's hands. There was blood splashed on the window and table, and pooling on the floor near other resident. CNA asked resident if he had hit other resident, and resident stated he had. CNA asked resident to walk away and allowed resident to leave the area unsupervised. Resident walked into 2nd other resident's room & began punching 2nd other resident while 2nd other resident laid in his bed. Both other residents were transported to hospital for emergency medical treatment. 1st other resident was admitted to hospital for a subdural hematoma, and 2nd other resident was admitted to the hospital for facial lacerations. The facility's failure to prevent physical abuse placed all residents on resident's unit in immediate jeopardy (IJ).*
    - *Plan of Removal:*
        - *1. The facility immediately assessed all involved residents for physical harm. (09/30/25)*
        - *2. Resident was immediately placed under 1:1 supervision, & his behavioral care plan was updated. (09/30/25)*
        - *3. The facility immediately notified all three resident representatives & medical provider. (09/30/25)*
        - *4. The facility sent all 3 residents out for immediate acute medical intervention. (09/30/25)*
        - *5. The facility immediately initiated in-service staff training r/t abuse prevention, behavioral health services, dementia care, and unit supervision to be completed by staff before the next available shift on 09/30/25 and completed on 10/01/25.*
        - *6. The facility screened all in-house cognitively intact residents for potential abuse or witnessed altercations. (09/30/25)*
        - *7. The facility screened all residents residing on the affected secured unit for abuse or psychosocial concerns. (09/30/25)*
        - *8. Administrative Nurse D completed EMR audits for all residents on affected unit for potential abuse. (09/30/25)*
        - *9. The facility's Quality Assurance Committee completed a meeting on 09/30/25.*
        - *10. The facility will interview 5 random staff members about behavioral management 5x/wk for 4 weeks, 3 times weekly for 4 weeks, then randomly thereafter. (09/30/25)*
        - *11. The facility will review all resident-to-resident interactions for last 30 days to validate root-cause analysis & causative factors. (09/30/25)*
        - *12. Facility will monitor all residents with known periods of aggression & interventions to reduce risks of recurring altercations & implement additional measures in the daily clinical meetings & risk meetings. (09/30/25)*
        - *13. All results will be reported to the Quality Assurance Committee*

F605 Right to be Free from Chemical Restraints

NE: SS=D: Failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk vs benefits for continued use of antipsychotic for 1 resident who had dx of dementia

- POS for Haloperidol for auditory & visual hallucinations dated 2-18-25; Seroquel BID for anxiousness dated 5-29-25; "Consent for Use of Psychoactive Medication Therapy" form lacked physician documentation for the physician's rationale, which included multiple unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued use of antipsychotic medication for resident, who had a dx of dementia. The facility was unable to provide physician documentation upon request

NE: SS=D: Failed to ensure 1 resident was free from antipsychotic medication use w/o proper indication for use written by physician

- POS for quetiapine, 25 milligrams (mg) by mouth at bedtime, for mood disorder; EMR lacked written physician rationale for use of an antipsychotic, quetiapine, w/o approved indication of use; Administrative Nurse verified pharmacist's recommendation included choices for physician to indicate use of quetiapine, & physician did not write a rationale for use of the unapproved antipsychotic. DON stated psychiatry had not been to facility to assess resident

NW: SS=D: Failed to ensure appropriate indication, or documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued use of 1 resident's antipsychotic medication

- Resident with dementia, depression, sleep apnea; POS for Seroquel for insomnia; Risperdal for dementia with agitation; EMR lacked documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk vs benefits statement for Seroquel & Risperdal use; MRR requested dx for use of antipsychotic meds & physician documented "no change" in 5-12-25 & not addressed continued inaccurate dx for antipsychotic med use

NW: SS=D: Failed to ensure 1 resident obtain approved diagnosis for use of Risperidone for dementia or physician's rationale for why this specific drug was necessary to treat condition

- Resident with Lewy body dementia, anxiety d/o MDD, impulse d/o; POS for Risperidone 1mg daily for Lewy Body Dementia with behavioral disturbance; MRR requested dx for use of resident's meds including Risperidone & physician responded drug was for Lewy Body Dementia with behavioral disturbance; staff confirmed verified dx for use of Risperidone unapproved & physician had not written rationale for unapproved use

F628 Discharge Process

SW: SS=D: Failed to provide 1 resident written notification of discharge to resident/representative as soon as practicable & failed to complete recapitulation of resident's stay

- EMR lacked baseline CP & comprehensive CP; POS for discharge home; Adm nurse reported discharge paperwork would be completed by charge nurse; charge nurse reported discharge paperwork would be completed by Adm nurse; no discharge summary for resident & facility did not completed paper discharge for or have resident/representative sign any discharge paperwork

NW: SS=D: Failed to provide written notification of transfer to 1 resident/representative for all applicable transfers/discharges. The facility failed to ensure written notification of transfers given to resident had required information. The facility further failed to notify the State Long Term Care Ombudsman (LTCO) of transfers/discharges for resident

- Resident transferred to hospital r/t change in condition; facility unable to provide written notification of transfer & bed hold acknowledgment for resident's transfer to hospital on 8-19-25; facility unable to provide documentation of LTCO notification for resident's transfer to hospital

NW: SS=D: Failed to notify State LTC Ombudsman of 1 resident's facility-initiated discharge to hospital

- NN documented change in condition, was alert & oriented but confused; physician ordered resident to be transported to hospital & admitted for hyperkalemia; EMR documented resident with 2nd hospital stay for UTI; then hospitalized r/t wheezing & dyspnea with CHF; EMR lacked documentation staff notified LTCO of resident's discharge to facility; SS stated do not send any notification of discharge to Ombudsman r/t residents' discharge to hospital but wound notify when resident discharged from facility, home or to another facility

NW: SS=D: Failed to notify the Office of the Long-Term Care Ombudsman (LTCO) for 2 residents & failed to provide 1 resident with written information r/t facility's bed hold policy when resident was transferred to hospital

- NN dated 04/19/24 at 12:25 PM documented resident was admitted to the hospital with left hip hemiarthroplasty; record lacked evidence facility notified the Ombudsman of the hospital transfer
- Record lacked documentation family or resident received bed hold notification or that the Ombudsman was notified of the hospital transfer

NW: SS=D: Failed to ensure appropriate indication, or documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued use for 1 resident's antipsychotic

- POS for Seroquel for MDD & anxiety; staff stated med first ordered 12-29-23 for dementia with behaviors

F636 Comprehensive Assessments & Timing

SW: SS=E: Failed to complete comprehensive MDS in timely manner for 6 residents

- Annual MDS completed on 3-18-25 & submitted 46 days later
- Sig change MDS completed on 8-7-25 & submitted 13 days later
- Sig change MDS completed on 7-29 & submitted 26 days later
- Comprehensive MDS 8-11-25 & submitted 9 days later
- Comprehensive MDS dated 8-13-25 & submitted 35 days later

- Comprehensive MDS dated 1-24-25 & submitted 52 days later

F637 Comprehensive Assessment After Significant Change

NE: SS=D: Failed to complete a significant change in the physical condition & complete a comprehensive "Significant Change MDS for 1 resident with addition of hospice services

- "Significant Change MDS" initiated on 08/28/25 was not completed for resident's admission onto hospice services. Resident was admitted to hospice services on 08/15/25; Resident's CAA was not completed in the 14 days required after the "Significant Change MDS was started on 08/25/25; EMR lacked order for admission for hospice services. The facility provided an order printed on hospice provider's certification form dated 05/15/25

F641 Accuracy of Assessments

SW: SS=D: Failed to accurately complete MDS for 1 resident r/t psychotropic meds

- MDS lacked documentation of antipsychotic & hypnotic that resident received during lookback period; POS for Abilify for depression & hydroxyzine for anxiety

F655 Baseline Care Plan

SW: SS=D: Failed to develop Baseline Care Plan for 1 resident

- EMR documented resident admitted on 8-11-25; EMR lacked Baseline CP

F656 Develop/Implement Comprehensive Care Plan

SW: SS=D: Failed to develop comprehensive CP for 1 resident

- EMR lacked comprehensive CP

NW: SS=D: Failed to develop comprehensive care plan for 2 residents, 1 for lymphedema & 1 resident dx of PTSD

- CP dated 09/02/25 lacked documentation of resident's dx of Lymphedema & directions for staff r/t compression glove & wrap
- CP dated 05/22/25 documented resident with dx of depression due to stroke, & staff would monitor resident for monitor for depression, hopelessness, sadness, verbalizing negative statements, repetitive anxious or health-related complaints, & tearfulness; CP lacked documentation of trauma-based triggers & individualized interventions for resident's dx of PTSD

F657 Care Plan Timing & Revision

SW: SS=D: Failed to revise CP for 1 resident r/t PU

- CP lacked any information r/t resident's wound care

NW: SS=D: Failed to ensure that 1 resident's CP was revised & interventions implemented to direct staff on resident care for insulin pump

- CP lacked staff direction for cares r/t use of insulin pump

NW: SS=D: Failed to revise & update CP with EBP for 2 residents urinary catheters & also failed to revise & update 1 resident's falls CP

- Resident with Foley catheter which required EBP but not included in CP x 2 residents
- Resident at risk for falls; NN documented resident with fall with injury; record lacked documentation of resident-centered intervention implemented to prevent falls & lacked documentation investigation completed for fall

F686 Treatment/Services to Prevent/Heal PU

NE: SS=D: Failed to thoroughly assess 1 resident's Stage 3 PU & Stage 4 PU

- Resident's "Skin Assessment" dated 09/22/25 included measurements of gluteal PU, 3.5 centimeters (cm) by 2.7 cm by 0.3 cm deep when resident returned from hospital. The assessment lacked documentation of characteristics of the PUs; Resident's "Skin Assessment" dated 09/29/25 documented gluteus PU measured 18.1 cm by 5.5 cm. The right heel PU measured 3.5 by 2.7 cm. The assessment lacked depth measurement or characteristics of wound. The facility lacked documentation physician was informed of the increased size of the PU.

NW: SS=D: Failed to provide physician-ordered interventions to treat or prevent pressure wounds for 1 resident when staff failed to apply a pressure relief air overlay device on resident's bed

- Resident at high risk for PUs; POS for PU treatment & offload both feet & heel pressure with pillow, boots & use of air overlay on mattress every day & night shift; "Skin Check" dated 08/27/25 stated resident's left heel PU was resolved; "Skin Check" dated 09/11/25 stated left heel scabbing intact & documented no measurements; no measurements or wound characteristics documented; "Skin Check" dated 09/17/25 stated left heel scabbing intact, & progress stalled; no measurements or wound characteristics documented; On 09/23/25 at 10:55 AM, LN checked resident's left foot dressing; LN washed hands & gloved, but did not don EBP; LN peeled heel wound dressing back & decided to change dressing; resident small open area, approximately 1 x 1 cm, on back of left heel; left foot very swollen, & toes were reddish in color; LN cleansed wound & applied new dressing; LN stated unsure when PU reopened; it was same area that resident had when resident was originally admitted; LN verified was supposed to measure wound, but had not; LN stated staff were to float resident's feet with pillows at night, & place pressure relief booties on during the day; LN verified resident's bed did not have air overlay mattress on bed as ordered

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=G (Past Noncompliance): Failed to ensure 1 resident remained free of accident hazards when staff pushed resident down hallway in shower chair; resident's right lower leg became entangled in shower chair causing resident to fall out of chair, resulting in right tibia & right fibula fx's

- Undated fall investigation documented on 10-7-25 staff wheeled resident from shower room via shower chair when resident's foot slipped off foot rail causing resident to fall face first onto floor; RCA determined to be resident tipped forward in shower chair while being transferred down hall; cameral footage reviewed & nothing appeared to visibly obstruct wheels & resident's feet still on footrest; ER eval found dx right tibia & fibula fx's with order for splint & orthopedic follow up
    - Plan of Removal:
        - No plan of removal specified in 2567 but past noncompliance determined

NE: SS=E: Failed to ensure rooms containing hazardous materials were kept locked & kept them out of reach of the 8 cognitively impaired//independently mobile residents

- On 09/29/25 at 07:04 AM, an initial walkthrough of facility was completed; inspection of 1 hall revealed unsecured "Telephone" room with empty boxes & a wire panel that was unlocked
- 1 resident room with uncontained O2 cylinder sitting directly on floor
- Resident with moderate fall risk; CP documented call light should be in reach of resident; observed resident & call light clipped to privacy curtain out of resident's reach; observed call light at top of bed & call light out of reach

NE: SS=D: Failed to provide 1 resident's fall interventions as directed by CP

- On 09/22/25 at 07:39 AM, resident laid in bed on back. Resident's pancake call light laid at the bottom of his bed out of reach
- On 09/23/25 at 09:37 AM, resident laid in bed, which was at the lowest position. Resident's floor mat was folded up next to Broda chair. Resident's fall mat was not next to his bed as CP'd

NE: SS=J (Past Noncompliance): Failed to ensure staff provided adequate supervision for cognitively impaired resident, who was at moderate risk for elopement.

- On 08/25/25 at approximately 12:50 PM, Administrative Staff opened facility door to allow 2 residents outside to sit on patio. Administrative Staff told LN resident was outside, seated in electric w/c. At 02:10 PM, EMS alerted facility that they responded to 911 call & found resident on ground approximately ½ mile from facility. Resident hit a curb in electric w/c, fell, & hit head. Facility staff were unaware resident had left facility until they received the EMS call. The facility's failure to prevent a cognitively impaired resident from leaving facility grounds w/o staff supervision placed resident in immediate jeopardy; CP lacked documentation r/t resident's outdoor privileges
    - Plan of Removal:
        - Notifications made to resident's PCP & DPOA
        - Statements obtained from staff members
        - Emergency QAPI meeting held with Medical Director, DON & ED
        - Emergency Resident Council held
        - Staff meeting on elopement policy & procedure held
        - Maintenance Director completed checks on all Exit doors
        - Elopement Book reviewed
        - Implemented list of residents with BIMS score of 13 & above to exit facility w/o supervision

NE: SS=D: Failed to implement 1 resident fall interventions r/t fall prevention signs

- On 09/29/25 at 07:22 AM, an inspection of resident's room revealed no "Call Don't Fall" sign in place in resident's room or bathroom as CP'd . Resident unable to locate signs in room. On 09/30/25 at 09:00 AM, an inspection of resident's room revealed no "Call Don't Fall" sign in place in resident's room or bathroom as CP'd.

NE: SS=J (Past Noncompliance): Failed to provide adequate supervision to prevent newly admitted resident who had documented intermittent confusion & exit-seeking/wandering behaviors, from leaving the facility on 10/18/25

- *Between 05:20 AM and 05:30 AM, w/o staff knowledge. Resident remained outside the facility (whereabouts unknown) for approximately five and a half hours, wearing only a hospital gown & no shoes, in approximately 65 degrees F temperature. Law enforcement located resident at 10:50 AM, approximately one mile from facility, wearing hospital gown & no shoes. The facility discovered the South egress door was not locked & did not alarm when pushed. This deficient practice placed resident in immediate jeopardy*
    - *Plan of Removal:*
        - *Administrative Staff audited all egress doors & found South egress door unsecured on 10/18/25.*
        - *Facility conducted an "Ad Hoc- Quality Assurance and Performance Improvement (QAPI) meeting" on 10/18/25.*
        - *Facility audited all residents for elopement evaluations on 10/18/25.*
        - *Facility educated staff on elopements, abuse, neglect, and exploitation (ANE), & egress doors on 10/18/25.*
        - *Maintenance evaluated & assessed all facility egress doors on 10/18/25.*
        - *Administrative Staff removed all alarm door keys & placed them in a lock box in medication room that required a code from designated staff to open it on 10/18/25.*
        - *The facility started door audits on 10/18/25 & continued them 2 to 3 times daily.*
        - *Facility conducted elopement drill on 10/20/25 & scheduled additional elopement drills thru January 2026.*

NW: SS=J (Past Noncompliance): Failed to ensure 1 resident received adequate supervision to prevent an elopement, which placing resident in immediate jeopardy

- Failed to ensure staff provided adequate supervision & immediate actions in response to door alarms to prevent an elopement for 1 resident who was cognitively impaired & had a hx of exit seeking. On 08/26/25 at 07:40 PM, resident exited facility unaccompanied by staff through the delayed-egress door leading out to the patio. Resident's WanderGuard alarmed, and the Nurse on duty visualized resident exit, but did not go to verify who the resident was or respond to the alarm immediately. After 2 minutes, nurse responded to the door along with another staff member. Staff went outside & found resident in circle drive that connected to street. Staff brought resident back inside facility placing resident in immediate jeopardy
    - Plan of Removal:
        - All staff re-educated on facility's elopement policy & immediate retrieval of resident during exit attempt in conjunction with review of elopement policy
        - Nursing counseling provided to LN & supervisor on facility's Elopement & Wandering policy
        - Elopement information reviewed for accuracy
        - Resident put on 1:1
        - CP meetings held with resident's family
        - 48-hour Behavior Monitoring log initiated to assess for exit-seeking behaviors, restlessness, or pattens warranting intervention
        - Pharmacy Consultant performed focused med review r/t resident's increased exit seeking to find family, brief recall of direction & intermittent agitation
        - Adm contacted door lock company to assess & repair any issues ID'd
        - DON submitted report to Kansas Stated Board of Nursing r/t LN's failure to communicate that LN did not have eyes on resident entire time of elopement

NW: SS=D: Failed to ensure fall interventions were implemented to prevent a fall which resulted in transport to local hospital & subsequent hip fracture & hematoma for 1 resident

- Fall CP documented resident high fall risk r/t poor balance, unsteady gait & fall assessments; intervention noted resident with cahir sensor alarm & staff to ensure alarm moved between recliner & w/c & staff would ensure floor dry, clear of clutter, call light within reach, needed items within reach & resident with appropriate footwear; CP documented staff would ensure sensor alarms working & connected when in use & remind resident to use call light before standing or when assistance needed; ADL CP documented 1 staff to assist resident with transfers with gait belt & walker & staff to check on resident during specific nighttime hours; incident report of fall documented resident w/o shoes; fall resulted in fx; on 11/06/25 at 09:05 AM, Administrative Nurse stated medical records documented resident had fall on 09/27/25 at 11:45 AM & after investigating it was determined resident did not have chair pressure pad alarm in recliner when resident fell, & alarm was located at end of bed; Administrative Nurse stated re-educated nursing & CNA staff on ensuring staff assisted residents to wear appropriate footwear before ambulating; Administrative Nurse stated reinforced fall prevention policy, including ensuring alarms were used as ordered & correctly placed, & reviewed importance of offering toileting assistance proactively to reduce unassisted transfers

F693 Tube Feeding Management/Restore Eating Skills

NE: SS=D: Failed to ensure 1 resident's water for tube feeding bag was marked with the date, time, & facility further failed to ensure resident's syringe was marked with date

- EMR lacked direction for staff as to when to change out syringe for resident's water flush; On 09/29/25 at 07:50 AM, resident laid in bed, with head elevated; resident receiving internal feeding & water; resident's internal water bag not marked with date, & syringe placed in a graduated cylinder not dated; internal water bag not marked with a date, & syringe placed in a graduated cylinder was not dated; Adm Nurse stated syringe & water bags changed daily

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure 1 resident's CPAP was stored in a sanitary manner

- On 09/28/25 at 08:36 AM, resident sat in his w/c, resident's CPAP mask laid on bedside table; resident's CPAP mask not stored in a sanitary manner

NW: SS=D: Failed to provide necessary respiratory care & services for 1 resident when staff stored uncovered nebulizer mask on top of nebulizer machine, & failed to ensure resident's nasal cannula was appropriately stored when not used

- On 09/29/25 at 08:45 AM, 1 resident's nebulizer mask was uncovered on top of the nebulizer machine; further observation revealed resident's O2 tubing & cannula wound up & placed between O2 concentrator handle & machine uncovered; On 09/30/25 at 07:45 AM, resident's O2 tubing & cannula was wound up & placed between the O2 concentrator handle & machine uncovered; on 09/30/25 at 02:45 PM, resident's nebulizer masked was uncovered on top of nebulizer machine; further observation revealed resident's O2 tubing & cannula was wound up & placed between O2 concentrator handle & machine uncovered; on 09/30/25 at 02:45 PM, resident stated O2 tubing & nebulizer mask should be in fabric bags on the machines; resident stated usually staff put them in their separate bags

F698 Dialysis

NE: SS=D: Failed to ensure 1 resident received care & services for dialysis consistent with professional standards of practice, including ongoing communication & collaboration with dialysis facility

- POS dated 09/16/25, directed staff to fill out Dialysis Communication sheet & send it with resident to dialysis & ensure that it was returned & completed; Upon review of the Dialysis Communication Form facility failed to provide the portion of the form's "Resident Condition" on 08/19/25, 08/30/25, 09/02/25, 09/09/25, 09/16/25, 09/20/25, and 09/27/25.

F699 Trauma Informed Care

NW: SS=D: Failed to ID trauma-based triggers r/t 1 resident's PTSD d/o characterized by acute emotional response to a traumatic event or situation involving severe environmental stress & failed to implement individualized interventions to prevent re-traumatization, & MDD

- CP dated 05/22/25 documented 1 resident with depression dx due to a stroke, & staff would monitor resident for depression, hopelessness, sadness, verbalizing negative statements, repetitive anxious or health-related complaints, & tearfulness; CP lacked documentation of trauma-based triggers & individualized interventions for resident's dx of PTSD

F700 Bedrails

NW: SS=D: Failed to assess the actual rail being used to assure safety for 1 resident

- Record lacked "Side Rail Assessment" & safe use for side rail; observed resident in bed with side rail on right side of bed with opening 12-1/2 inches wide & 18 inches from top fo rail to mattress; EMR lacked assessment for siderail;

F725 Sufficient Nursing Staff

NW; SS=F: Failed to ensure adequate daily nursing staff were always available to meet the needs of residents residing in facility

- Review of the nursing daily staffing schedules from 07/01/24 to 09/29/24 revealed on 08/10/24 and 09/21/24 a lack of LN coverage 24 hours a day; Adm Nurse stated worked on days in missing time slots but was salaried & did not clock in so facility had no documentation to verify Adm Nurse worked during missing time slots

F726 Competent Nursing Staff

NW: SS=D: Failed to follow physician orders to obtain adequate blood samples for 1 resident's laboratory testing & further failed to obtain physician involvement for direction r/t continued Coumadin & Lovenox administration w/o required monitoring

- Resident with cerebral infarction affecting rt dominant side, aphasia, HTN, a-fib; resident returned from hospitalization with POS for daily INR until goal INR met; POS for Coumadin & Lovenox; MAR lacked documentation r/t order to draw PT/INR & no lab obtained that day & lacked evidence physician notified & resident received Coumadin & Lovenox; next day EMR documented staff attempted 2 x's to draw blood for INR but did not draw adequate amount for testing & unable to obtain sample on 2nd attempt & staff did not notify physician of failed efforts & inability to obtain INR result but resident received anticoagulants; multiple further days resident did not get blood drawn as ordered & 5 days later, EMR documented resident had PT/INR that was critically high;

F730 Nurse Aide Performance Review-12 hr/yr In-Service

SW: SS=F: Failed to ensure complete required annual evaluation for 2/5 CNAs sampled

- 2 CNA personnel files with 1 with nothing after 7-25-24 & 1 with nothing after 5-6-24; Adm nurse stated planning on setting up evals on calendar & should be completed in timely manner

SW: SS=F: Failed to complete annual performance review at least once every 12 months for 1/5 CNAs reviewed

- Review of 5 employee personnel files revealed 1 CNA lacked annual performance review in personnel file & CNA had worked in facility over 1 year

NW: SS=F: Failed to ensure required annual performance reviews completed for 3 members reviewed

- 3 CNAs reviewed lacked annual review

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) had identified & reported irregularities for 1 resident.

- Administrative Nurse stated the CP should have identified resident's lack of an AIMS test r/t administration of Reglan. Administrative Nurse stated had notified CP that resident should have had an AIMS test completed r/t to medication Reglan. Administrative Nurse stated had notified corporate office to initiate UDA to trigger to be completed as needed.

NW: SS=D: Consultant Pharmacist (CP) failed to obtain an approved indication for use for Seroquel for 1 resident & Risperdal for 1 resident, & failed to have monthly pharmacy Medication Regimen Reviews (MRR) for 2 residents

- EMR lacked documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and risk vs benefits statement for Seroquel and Risperdal use; "Pharmacy Review," dated 05/12/25, documented resident received Seroquel 50 mg at bedtime & requested provider for a diagnosis for use of antipsychotic medication; pharmacist documented antipsychotic use for behavior of dementia shows a 35 % increase in mortality and a 50 % increase in hospitalization;

continued review of pharmacist's request revealed physician documented “No change.”; review of pharmacist review after 05/12/25 until present revealed pharmacist had not addressed the continued inaccurate diagnosis for antipsychotic med use

- Review of the CP’s month regimen review (MRR) for 1 resident revealed facility lacked documentation/record of resident’s medication review for months of September 2024, November 2024, December 2024, January 2025, & March 2025
- Review of 1 resident’s CP’s monthly medication regimen review (MMR) from August 2024 to present revealed facility unable to provide documentation of the CP MMR for the months of September to December 2024, as well as January & February 2025

NW: SS=D: Failed to ensure consult pharmacist (CP) notified physician or DON of need for further documentation r/t continued use of Risperidone for 1 resident r/t unapproved diagnosis

- Cited findings noted in F605 r/t POS for Risperidone for Lewy Body Dementia

NW: SS=D: Failed to Consultant Pharmacist (CP) ID’d lack of specific parameters for 1 resident’s use of PRN opioid & diuretic use & 1 resident’s unapproved diagnosis for use of antipsychotic

- POS dated 09/23/24 directed staff to administer oxycodone 5 mg p.o. q 3 hours PRN pain, 1-3tablets q 3 hours PRN; order lacked parameters r/t specifics for level or type of pain & how many tablets to give based on level or type of pain; POS dated 08/26/25 directed staff to administer bumetanide 0.5 mg by mouth q 24 hours PRN for edema & order lacked specific guidelines r/t edema; MRR dated 12/17/24 thru 09/24/25 lacked recommendation or clarification on specific parameters r/t PRN use of oxycodone & bumetanide
- Cited findings noted in F605 r/t inappropriate dx for use of Seroquel for MDD & anxiety; staff confirmed CP did not address physician’s dx for Seroquel in monthly reviews

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure dosing instructions for Voltaren gel for 1 resident

- POS for Diclofenac sodium external gel 1 % apply to the rt hip topically every 6 hrs PRN for pain, dated 09/17/25; order lacked dose

NE: SS=D: Failed to ensure an AIMS” test to monitor for adverse effects from the medication Reglan for 1 resident

- Cited findings noted in F756 r/t Reglan

NW: SS=D: Failed to hold BP medication per physician-ordered parameters for 1 resident

- POS dated 04/11/24, directed staff to administer midodrine 0.5 mg p.o. BID a day for orthostatic hypotension; order directed to hold if BP was greater than 140/85; MAR documented administration of med when BP over ordered parameters on 10 occasions from July thru Sept 2025

NW: SS=D: Failed to obtain parameters for PRN med r/t to opioid & diuretic use

- Cited findings noted in F756 r/t lack of parameters for administration of Oxycodone PRN pain & Bumex PRN edema; LN reported resident determined what dose of oxycodone resident wanted; LN reported resident usually c/o of pain all over body when LN asked about pain; LN stated resident had changes to dose of bumetanide, and resident would let staff know if resident wanted PRN bumetanide; LN stated order for oxycodone & bumetanide lacked parameters or specified edema or pain levels r/t use

F760 Residents are Free of Significant Med Errors

SW: SS=D: Failed to ensure accurate administering of multiple meds as ordered by physician for 1 resident r/t pain med & meds to treat constipation

- POS for Gabapentin 100mg p.o. BID for neuropathy ordered 9-5-25; Senna-S 8.6-50 mg 2 tabs BID for constipation ordered 9-5-25; MAR dated 9-1-25 thru 9-30-25 lacked evidence facility administered on 1 occasion for Gabapentin & 4 occasions with Senna-S

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to, in accordance with state & federal guidelines, ensure that a vial of TB serum was labeled properly after being opened

- On 9-30-25, observed vial of TB in med fridge; vial cap removed; order date of 8-29-25

NE: SS=E: Failed to appropriately store medications & biologicals when staff failed to ensure med carts were always locked when cart was not within the nurses' line of sight

- On 09/22/25 at 07:33 AM, treatment cart containing residents’ treatment supplies, PRN creams, & insulin pens was unlocked. The cart was in 1 Hall, & Administrative Nurse locked med cart

NE: SS=E: Failed to remove outdated or expired medication from potential administration to residents

- 1 Med cart contained 2 expired meds; 1 med cart with E-kit box with 2 vials of Ativan with expired date

NW: SS=D: Failed to label 1 resident’s insulin flex pens when initially opened for use & when expired

- Observed facility med cart revealed resident’s Lantus flex pen not labeled with opened date or expired date

F770 Laboratory Services

NW: SS=D: Failed to obtain adequate blood samples for 1 resident’s laboratory testing & further failed to obtain physician involvement for direction related to continued Coumadin & Lovenox administration w/o required monitoring

- Cited findings noted in F726 r/t staff failure to obtain PT/INR as ordered for resident with 2 anticoagulants ordered

F801 Qualified Dietary Staff

SW: SS=F: Failed to employ full-time CDM

- Dietary Mgr stated did not have certificate or experience with food handling prior to taking position & was currently in classes for CDM; Adm stated placed DM in position & unaware needed to have certification, specialized training or experience & confirmed DM in classes to obtain CDM

NW: SS=F: Failed to provide services of a full-time CDM for all residents residing in facility & received meals from the kitchen

- Dietary staff verified not CDM

NW: SS=F: Failed to employ a full-time CDM for residents residing in facility & receiving meals from facility kitchen

- Dietary staff stated had just started a couple months ago & was not certified or started taking classes yet

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NW: SS=F: Failed to take food temps before serving noon meal

- Observed dietary staff did not obtain food temps prior to serving meal; staff stated had taken temps but had not documented temps; when prompted to temp, meat temped at 105 degrees for pureed meal

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to prepare & serve food under sanitary condition to prevent potential for foodborne bacteria placing residents at risk for foodborne illnesses

- Observed: dented can, bag of carrots with frost in bag covering carrots; undated hashbrowns; expired foods; food items with frost; mini-freezer w/o logged temps

SW: SS=F: Failed to prepare & serve food under sanitary conditions to residents of facility appropriately to prevent potential for foodborne bacteria in 1/1 kitchen & 1/2 DRs

- Observed 3/3 fridges with dried-on food & fluids on fronts & rubber strips around perimeter of doors with black substance; fridge with spilled liquid on inside shelf; cart with food debris on bottom; shelf of prep table with food debris; 2/2 covered trash cans with dried-on food debris on fronts; cart with black, rubbed-in debris on top; microwave with dried-on food debris on all sides & top of oven
- Kitchenette with counter with cabinet doors with deep grooves; microwave with dried-on food debris on all sides & top of oven

NW: SS=F: Failed to store, prepare, distribute, & serve food by professional standards for food service safety in facility's kitchen

- Observed: 3 overhead fluorescent light fixtures with 2 bulbs in each fixture & multiple other areas in kitchen with gray hanging lint; air vent grills covered with brown grease/sticky substance & gray fuzzy substance blowing directly on food prep & stove cooking area with same in dishwashing area; fire suppression spigots covered with brown fuzzy grey substance on pipes & spigot area

NW: SS=F: Failed to store, prepare, distribute, & serve food by professional standards for food safety, & failed to consistently document sink & bucket PPM sanitation on facility's PPM log

- Observed kitchen tour, daily temp logs for 7 freezers & 3 fridge logs for Sept lacked documentation of daily temps on multiple occasions during September; daily food temp logs lacked meal temps on multiple meal occasions

F838 Facility Assessment

SW: SS=F: Failed to conduct a thorough facility wide assessment to determine resources necessary to care for residents competently during both day-to-day operations & emergencies affecting all residents residing in facility

- Assessment did not ID specific staffing levels needed for each unit, number of RN, LPN, CMA & CNAs needed for each shift, patient acuity & census; assessment lacked staffing levels required for each shift to include evenings & weekends; assessment lacked information for contingency staffing plans for events that did not require activation of facility's emergency plan but had potential to impact resident care; Adm unaware of requirement to include staffing levels, contingency staffing plan or staff recruitment plan in Facility Assessment

F849 Hospice Services

NE: SS=D: Failed to provide a description of medication & equipment provided to 1 resident by hospice

- CP lacked equipment provided by hospice services & medication that would be covered by hospice services. Resident's EMR lacked an order for admission for hospice services

NW: SS=D: Failed to ensure coordinated care & services provided by facility with care & services provided by hospice for 1 resident

- CP lacked instruction on services provided by hospice, including frequency & type of support visits, supplies & medical equipment provided by hospice, medications covered by hospice, & hospice contact information

F851 Payroll Based Journal

NW: SS=C: Failed to submit complete & accurate staffing information thru PBJ as required

- PBJ report provided by the CMS for Fiscal Year (FY) Quarter 4 2024 (July 1- September 30) indicated facility had no LN coverage 24 hours a day on 5 days; review of facility's daily nursing staff coverage revealed the facility had LN coverage 24/day on those cited dates, & revealed facility had adequate LN coverage

F867 QAPI/QAA Improvement Activities

SW: SS=F: Failed to complete a PIP based on ID, investigation, analysis, & prevention of adverse events in facility within past year

- Upon request facility unable to provide evidence of PIP completed within last year

F868 QAA Committee

NW: SS=F: Failed to maintain a Quality Assurance Assessment and Assurance committee (QA&A) that met quarterly & had required membership in attendance

- QA committee attendance roster for 4 provided & Medical Director signed attendance for 2 of the meetings

NW: SS=F: Failed to ensure Medical Director attended QAA Committee quarterly meetings

- On 09/30/25 at 02:30 PM, the facility provided QAA committee attendance rosters for 03/01/24, 10/23/24 (6 months no meeting), 01/22/25, and 04/16/25 until present (6 months no meeting), & in which the medical director had been present for 3 meetings but had not been present for the 01/22/25; facility only provided documentation for 3/4 quarters of 4 required for the year 2024 to 2025.

F880 Infection Prevention & Control

SW: SS=F: Failed to complete system of surveillance designed to ID possible communicable diseases or infections before spread to other persons in facility; additionally, failed to complete system for preventing, IDing, reporting, & investigating, & controlling infections & communicable diseases for all residents with potential to affect all residents

- Facility unable to provide antibiotic & infection surveillance logs; Adm Nurse stated no electronic or paper records to show collection & analysis of data to track infection rates & ID trends; stated completed verbal report of facility's infections & ABT at QA meetings

SW: SS=F: Failed to ensure adequate infection control practices r/t handling, processing, & storage of resident clothing & linen

- Observed soiled linen sorting area with overflow of laundry in 3 barrels in corner resulting in direct contact with walls; 6 uncovered pillows stacked on top fo overflowing linen barrel with bagged, unmarked clean clothing & 1 pillow with torn, unsanitary vinyl cover; inside door of dryer with unsealed, worn surface & rust colored substance with irregular, unsealed & unsanitary surface; folding table with peeling & missing laminate

NE: SS=E: Failed to ensure 1 resident's ventilator mask was stored in sanitary manner, failed to implement adequate hand hygiene, & further failed to ensure 1 resident's catheter not on the floor

- On 09/29/25 at 07:15 AM, resident sat in recliner in room & catheter bag rested on floor, & no dignity bag noted to cover bag; urine visible in collection bag
- On 09/29/25 at 08:36 AM, resident sat in w/c; resident's CPAP mask laid on bedside table & mask not stored in sanitary manner
- On 9-30-25 observed LN administer Volaren gel: entered 1 resident's room w/o performing hand hygiene; placed med tray on bedside table w/o barrier, assisted resident with clothing, then applied gel then removed gloves w/o performing hand hygiene upon removal then picked up tray & entered another resident's room w/o performing hand hygiene & again failed to perform hand hygiene after removal of gloves then repeated same actions with another resident's gel
- On 9-30-25 LN prepared resident's med for G-tube administration; after entering resident's room, donned gloves but failed to perform hand hygiene then placed tray with resident's meds onto roommate's bedside table then attempted to perform water flush w/o success then place syringe into tray with open tip directly on bottom of tray

NE: SS=F: Failed to ensure 1 resident's CPAP mask was stored in a sanitary manner, & further failed to develop, implement, & maintain a water management program to reduce risk of Legionella & other waterborne pathogens

- On 09/22/25 at 08:13 AM, resident sat in recliner, waiting for breakfast. Resident's unbagged CPAP mask rested directly on bedside table. There was no bag visible for storing the CPAP mask. Resident stated mask was usually not stored in a bag & normally laid on bedside table. Resident stated did not have bag for CPAP mask
- On 09/22/25 at 02:10 PM, Administrative Staff brought binder with printed directions on monitoring for Legionella. The notebook contained documentation of Legionella testing, the last test completed on 06/2025, & information provided by CMS on how to track Legionella. The documentation was not specific to facility. The facility lacked documentation of risk assessment & evidence of monitoring to identify potential sources of Legionella growth

NE: SS=E: Failed to follow sanitary infection control practices r/t wearing PPE r/t residents on EBP.

- On 09/30/25 at 07:36 AM, 1 CNAs used a total lift to transfer 1 resident who had wounds & a urinary catheter, from bed to a w/c. The CNAs did not wear gowns for infection control during transfer
- POS dated 09/18/25 directed staff to use EBP with dressing, bathing, transfers, changing linens, providing hygiene, toileting or peri care, device care, or wound care. On 09/30/25 at 10:25 AM LN prepared resident's medication for administration through the g-tube. LN sanitized hands by using alcohol gel, placed gloves on, & entered the room. Resident's door had a sign with information regarding EBP & a clear plastic pocket container with blue plastic gowns. LN proceeded to administer medications & water through g-tube w/o wearing protective gown.

NW: SS=F: Failed to ensure that EBP signage was posted in or near residents' rooms, which communicated types of precautions & PPE required before performing resident cares

- 4 residents had PPE inside their rooms; residents had evidence of PPE in rooms, but lacked signage inside or outside rooms that indicated that resident was on EBP

NW: SS=F: Failed to implement EBP for 2 residents r/t urinary catheter care; facility also failed to have a structured Infection Control program

- Cited findings noted in F657 & F686 r/t EBP for 2 residents
- Review of facility ICP lacked documentation for tracking infections from October 2024 to Sept 2025 which included type of infection, ABT use, resolution fo infection & additional cultures, IDing, tracking, monitoring, &/or reporting infections; IP verified had not tracked infections for last few months

NW: SS=F: Failed to ensure sanitary & comfortable environment to help prevent development & transmission of communicable diseases & infections when staff failed to provide EBP for 1 resident

- On 09/30/25 at 08:20 AM, observation revealed resident sat in w/c in room; LN & Consultant entered resident's room & asked resident if could change dressing on resident's right outer ankle; resident replied, "Sure."; observation revealed all items needed for dressing change were on a barrier on resident's bed; Consultant & LN applied gloves, Consultant removed resident's sock & dressing on outer ankle, to reveal scant amount of green drainage on dressing, measured the wound area, discarded dressing in a trash can, then removed & discarded gloves; LN cleansed wound area with normal saline on gauze pad, removed & discarded gloves; both applied new gloves; Consultant stated that since wound had green drainage, instructed LN to apply Therabond & cover with opsite; LN removed & discarded gloves, left room, & came back with a Therabond dressing; LN applied gloves & placed Therabond dressing on wound area & covered it with an opsite dressing; LN verified resident not on EBP but should be

NW: SS=F: Failed to use appropriate barriers while sorting soiled laundry

- On 11/06/25 at 08:37 AM, while on tour of laundry department, Housekeeping Staff stated soiled laundry was sorted using only gloves for PPE & said staff did not wear gown or other barriers

F881 Antibiotic Stewardship Program

SW: SS=F: Failed to ensure staff adhered to principles of antibiotic stewardship through monitoring for appropriate use of antibiotics prescribed to prevent antibiotic resistance & spread of MDROs within facility

- Facility unable to provide antibiotic & infection surveillance logs; Adm Nurse stated no electronic or paper records to show collection & analysis of data to track infection rates & ID trends; stated completed verbal report of facility's infections & ABT at QA meetings

F883 Influenza & Pneumococcal Immunizations

NW: SS=E: Failed to offer a pneumococcal PVC20 immunization for 3 residents per guidance from CDC

- EMR documented resident received Prevnar 13; facility lacked documentation that resident had been offered or refused any further pneumococcal vaccinations for 3 residents