November 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

April 2025
June 2025
July 2025
August 2025
September 2025
October 2025

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to treat residents in a dignified manner when 1 resident received personal care w/o privacy placing resident at risk for decreased psychosocial well-being & embarrassment

- *Observed LN entered resident's room w/o shutting door & did not close curtain to provide privacy then performed dressing change on both resident's legs with door & privacy curtain open leaving resident visible from hallway*

F552 Right to be Informed/Make Treatment Decisions

SE: SS=D: Failed to inform 1 resident/representative about risk & benefits of taking an antianxiety

- Resident with Alzheimer's disease, anxiety, psychotic d/o & MDD; POS for Buspar TID for anxiety d/o; MRRs noted no requests for staff to obtain Informed Consent from representative; record lacked evidence of informed consent r/t Buspar

F558 Reasonable Accommodations Needs/Preferences

SW: SS=D: Failed to ensure staff acknowledged & implemented 1 resident's preferences r/t receiving medications after meals

- *Resident with DM, BIMS 13; CP lacked direction to staff r/t resident's preference to have meds administered 30 minutes to an hour after food to prevent resident from getting sick to stomach; POS for 7 meds including ABT, cardiac meds, anticonvulsant, anticoagulant, insulin & med for indigestion; POS lacked direction to administer any ordered meds with food or following food as resident preferred; MAR revealed resident refused morning meds on 4 occasions from 8-13-25 thru 9-12-25; observed resident stated "he was his own person & should be able to made decisions about his care; no one was going to tell him what to do"; resident stated got angry when tried to get meals on time & explained had to have food before took meds or would get sick & staff did not listen to requests & had to tell staff over & over & made him angry; observed CMA entered resident's room & told resident giving meds & resident replied in loud voice that he would only tell them 1 more time that could not take meds because he had not eaten yet & it would make him sick; EMR lacked guidance to give resident meds with food as preferred*

F580 Notify of Changes

NW: SS=D: Failed to notify 1 resident's representative when resident had a change in condition placing resident at risk for a lack of required decision from representative for treatment

- *NN documented resident observed resident with vomiting & diarrhea throughout day & staff administered Maalox & Imodium; record revealed lack of documentation that representative informed of change in condition; 2 days later NN documented resident with "rough weekend" with nausea, vomiting & diarrhea & hard time transferring & nurse notified physician & representative 3 days after resident's initial change in condition*

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E: Failed to maintain a clean, comfortable, & homelike environment in common living area for residents of facility placing residents at risk for decreased quality of life.

- *Observed strong odor of urine when entering facility; observed resident in recliner & pants wet on front between legs & seat of chair saturated & strong odor of urine then 2 CNAs transferred resident with sit-to-stand lift & could see recliner & resident were saturated & did not clean chair but requested someone call housekeeping to clean chair & chair remained unclean for 22 minutes then 5 minutes after that housekeeping staff brought shampooer into living area & shampooed seat of recliner; recliner continued to have multiple stains on armrest, seat, footrest & back of chair where head rests; resident's representative reported smell in facility "very bad" & remarked smell worse on family member's wing; resident's husband reported smell in facility worse over last 6-8 months*

SE: SS=E: Failed to ensure a safe, clean home-like environment in all areas of facility including resident rooms

- Observed resident rooms with missing paint with exposed sheetrock & BR door with missing pain with exposed wood & metal door frame with missing paint with exposed metal; observed numerous ceiling tiles in hallways with water stains & many braking & flaking & several bulging, creating open access to drop-ceiling space above tiles; clean utility room with ceiling tiles around AC unit with water stains & wall molding of countertop pulling away from wall & area with scraped & with multiple exposed areas of sheetrock; handrail with large area scraped & with exposed wood & ceiling tiles with water stains

F600 Free from Abuse & Neglect

SW: SS=J (Plan of Removal to G): Failed to ensure residents remained free from physical & sexual abuse

- *On 5-12-25 resident admitted to facility with hx of inappropriate behaviors; on 5-14-25 resident grabbed & hit cognitively impaired resident & staff placed resident on 1:1 until discharged to behavioral health hospital on 5-15-25; resident returned to facility on 5-27-25 & facility did not implement interventions for resident to prevent further resident abuse; on 6-1-25 resident bit another resident's finger, causing bleeding; resident back to behavioral health unit on 6-5-25 & returned to facility on 6-18-25; on 6-21-25 resident & another resident had altercation where slapped each other & resident grabbed other resident's arm; on 6-28-25 resident placed hand on another cognitively impaired resident's clothed genital area & facility did not complete investigation into event or implement interventions to prevent further abuse; on 8-5-25 resident grabbed other resident's breast while other resident slept & staff placed resident on 1:1 x 10 days but failed to administer resident's physician-ordered med to address sexual behaviors; on 8-24-25 resident put hand inside another resident's brief while another resident slept in bed; failure to implement effective interventions to prevent physical & sexual abuse placed 3 other residents in immediate jeopardy*
- *Plan of Removal:*
  - *Staff in-services on facility's ANE policy & procedure & De-Escalation Tool; staff not allowed to work until verification of in-service training obtained*
  - *Resident accepted to another facility with estimated discharge of 11-1-25 or sooner*
  - *To ensure resident received Depo-Provera, DON added administration date to calendar as reminder to ensure that med was on hand by due date every 2 weeks*
  - *All staff educated on 9-17-25 r/t resident's specific behaviors that indicate that resident might be escalating & appropriate actions to take in response*
  - *New staff (DON & Adm) in-serviced on 9-17-25 to do root cause analysis when resident placed on 1:1 monitoring including what led up to incident, what behaviors led up to incident, & what to look for after resident was removed from 1:1 monitoring; entire IDT also received in-service on 9-17-25*
  - *Facility & corporate entity modified current 1:1 policy to create ongoing monitoring once residents removed from 1:1 oversight with regional support to monitor effectiveness of interventions placed*
  - *QAPI meeting on 9-17-25 to review*

NE: SS=J (Past Noncompliance): Failed to prevent staff abuse of residents when Hospitality Aide took demeaning/humiliating photos of several cognitively impaired residents, w/o residents' consent, knowledge, or permission

- *Photos were taken some time in May of 2025 in each resident's personal environment during care. The photographs revealed: 1 resident lying in bed on left side unclothed from waist down & exposed; 1 resident in bed on back with head tilted to the side, asleep, & unidentified CNA standing on 1 resident's bed at head of bed using a draw sheet to pull resident up in bed, with resident exposed from waist down; photos were taken and remained on the hospitality aide's personal cell phone in May 2025, and aide texted them to at least 1 additional staff member, a CNA, who later got into a fight with hospitality aide, & emailed photos to another facility staff member in July of 2025; based on reasonable person this deficient practice placed 3 residents at risk for fear & psychosocial impairment*
- *Plan of Removal:*
  - *ANE & cell phone usage policy training to all onsite staff, completed for all staff & staff not permitted to work next shift w/o having re-education*

NE: J (Past Noncompliance): Failed to prevent sexual abuse when 1 resident used topical pain medication as lubrication & penetrated cognitively impaired resident anally & vaginally

- *On 07/11/25 at 03:05 PM, cognitively impaired resident reported to LN she felt nauseated, and LN noted resident to be anxious. Resident stated "other resident" utilized topical pain medication (Voltaren) during a sexual encounter, as lubrication, resident felt sick, & reported hurting & bleeding. LN asked resident to clarify if it was used in her vagina or rectum, and resident stated vagina. Resident reported other resident had put it on himself, and then "it" went in. Resident was unable to provide a date or time when the incident with other resident occurred, but stated it was a couple of days ago. Resident was tearful, voiced embarrassment, reported feeling ashamed, & said she told other resident to stop, but other resident did not stop. The Social Services Staff took resident to the hospital, where resident reported sexual activity & bleeding. Resident told emergency room (ER) doctors resident was penetrated anally by other resident. The examination revealed a small internal hemorrhoid and excoriation of the rectal tissue. Resident stated when other resident touched resident, resident felt afraid, helpless, & scared. Resident continued to have uncontrolled anxiety & tearfulness, was found shaking uncontrollably in bed, & was very difficult to calm. This deficient practice placed resident in immediate jeopardy, & other female residents at risk for sexual abuse*
- *Plan of Removal:*
  - *Other resident placed on 1:1 & has since been discharged*

- *All staff re-educated on ANE after incident, completed prior to survey*
- *Social Worker will meet with resident weekly x 4 weeks*
- *Facility interviewed alert & oriented female resident r/t safety*

NW: SS=J (Plan of Removal to G): Failed to prevent an episode of staff-to-resident physical abuse.

- *On 06/28/25 at approximately 06:40 PM, CNA took cognitively impaired resident to BR, then called for assistance, & other CNA came to resident's room. CNA told other CNA that resident bit CNA, so other CNA took over care. Other CNA noticed resident was dabbing face with toilet paper, & the toilet paper had blood on it. Other CNA asked resident what happened, and resident said, "Honey, can you believe it? Her fist hit my jaw." Other CNA observed a purple bruise on resident's right jaw & blood in resident's mouth. Other CNA informed LN and CNA of resident's statement. CNA denied hitting resident. Following incident, resident became scared & paranoid to be in room, afraid "she" was there, & did not want anyone to touch resident. The facility's failure to prevent staff-to-resident physical abuse placed resident in immediate jeopardy*
- *Plan of Removal:*
  - *Social Services would follow up immediately with resident r/t psychosocial wellness & continue to offer resident support regarding incident*
  - *All facility staff re-educated on ANE*
  - *Adm Nurse interviewed all alert & oriented residents to establish residents' safety & residents felt free from staff abuse & neglect*
  - *Held QAPI meeting immediately concerning incident*
  - *Notified resident PCP & responsible party*
  - *Notified law enforcement & Medical Director*

F602 Free from Misappropriation/Exploitation

NE: SS=J (Past Noncompliance): Failed to protect 1 cognitively impaired resident from misappropriation of funds. On 07/21/25, it was discovered that Administrative Staff C downloaded resident's credit card account information to their cell phone to make purchases for resident. Administrative Staff C later admitted to purchasing items on resident's card account for themselves. This deficient practice placed resident, a cognitively impaired resident, in immediate Jeopardy, causing resident emotional distress & a monetary loss of approximately $6000.00

- *Facility reported incident received on 7/21/25 at 02:19 PM recorded a facility staff member informed Administrative Staff that staff member had attached 1 resident's credit card/debit information to Administrative Staff's phone to make purchases for resident, but "forgot" to remove the card from her phone, which resulted in a charge to resident's account the next time Administrative Staff used the card for a personal purchase. The report documented Administrative Staff reviewed resident's bank account statement & discovered several suspicious charges. Administrative Staff suspended alleged perpetrator Administrative Staff & directed staff member to leave the building and notified law enforcement; investigation lacked documentation r/t amount of money charged to resident's account & lacked documentation r/t when personal charges began; account revealed suspicious charges exceeding $5,987.14 since February 2025 with most occurring in July 2025*
- *Plan of Removal:*
  - *Staff member immediately suspended & subsequently terminated*
  - *Audit of all resident accounts performed & no other concerns noted*
  - *Meeting with resident held & discussed matter & facility offered, & resident accepted counseling to cope with feelings of betrayal & loss of trust*
  - *Door code changed to staff member's office & all keys were reclaimed from terminated staff member*
  - *Resident's credit card was returned to resident & facility took resident to bank where new, uncorrupted card was issued to resident*
  - *Facility conducted all-staff in-service r/t facility ANE policy, timely reporting policy & review of Elder Justice Act with employee signatures*
  - *Facility notified law enforcement who responded & met with resident & ongoing criminal investigation began*
  - *Facility held impromptu resident council meeting to inform residents there was no gifting of or sharing of sensitive information*

NE: SS=E (Past Noncompliance): Failed to ensure 7 residents remained free from misappropriation of medications creating risk of missed meds & further misappropriation of meds for affected residents

- *Facility's "Investigation" dated 08/27/25, documented on 08/20/25, Licensed Nurse (LN) reported to Administrative Nurse & Administrative Staff a noted color discrepancy for several liquid narcotics. Facility immediately started investigating, & staff assessed residents on liquid narcotics for pain & gave medication as needed. The facility audited liquid narcotics with no other discrepancies noted. The facility notified the provider and affected residents' representatives. The facility reported the discrepancies to the police. The facility suspended LN on 08/20/25 pending the investigation, as LN worked on both units during the timeframe. The facility contacted the pharmacy, and Consultant went to the facility to investigate. Consultant discovered 7 residents had liquid morphine that appeared to be different in color or smell. Consultant destroyed the tampered medications per protocol. The facility reviewed camera footage & was unable to identify any suspicious activity of diversion. The facility identified multiple staff members who had access to the medications in question and were unable to narrow down the exact date the meds may have been tampered with. The investigation included the "Individual Resident's Controlled Substance Record" sheets for the*

affected residents. The sheets revealed the following last doses of liquid morphine received for each affected resident: 1 resident on 08/20/25, 2nd resident on 08/07/25, third resident on 03/01/25, 4th resident on 04/07/25, fifth resident on 07/22/25, sixth resident on 05/02/25, and seventh resident never received any doses

- *Plan of Removal:*
  - *Reported liquid morphine discrepancies to policy*
  - *Notified pharmacy*
  - *Pharmacy consultant inspected 7 bottles of MS for signs of tampering & reported findings to facility*
  - *Adm nurse & pharmacist destroyed tampered MS bottles*
  - *Facility replaced 1 resident's MS as that resident was only 1 actively using it*
  - *Pharmacy planned to bill facility for diverted MS bottles that residents paid for*
  - *Conducted Ad-Hoc QAPI meeting*
  - *Education LN & CMAs on Controlled Substances & Elder Justice Act*

F605 Right to be Free from Chemical Restraints

SE: SS=D: Failed to attempt a GDR for 1 resident's antipsychotic medication

- Resident with Alzheimer's disease, anxiety, psychotic d/o & MDD; POS for Seroquel 25mg in evening for psychotic d/o with delusions; MRRs with no requests for GDR for Seroquel; LN confirmed no request for a GDR, no attempt for a GDR, & no risk vs benefits statement for Seroquel

NE: SS=E: Failed to ensure PRN psychotropic medication had a stop date for 3 residents; facility also failed to complete GDRs with physician's rationale of risk vs benefits, & if GDR was clinically contraindicated for continued use of psychotropic medications for 3 residents

- Resident with schizophrenia; POS for Asenapine & Aripiprazole for schizophrenia; EMR lacked documentation r/t recommendation from consulting pharmacist for GDR for both meds; Adm nurse verified facility lacked documentation r/t GDRs attempted & facility did not try DGRs with residents
- Resident with schizoaffective d/o, Bipolar, severe intellectual disabilities & hypothyroidism; MDS indicated resident with hallucinations, delusions & other behavioral symptoms; POS for Clozaril, Invega Sustenna Suspension; Lamotrigine; Mirtazapine; Trazodone routine & PRN; Haldol routine & PRN; Trazodone PRN lacked duration or stop date; MRR from 10-9-24 thru 10-6-25 lacked recommendation r/t GDR of psychotropic drug use or required duration for PRN antipsychotic & antianxiety; Adm nurse stated due to clients facility cared for, facility did not do GDRs & pharmacist had not recommended them either
- Resident with schizoaffective d/o, Bipolar, COPD; POS for Haldol routine & PRN, Quetiapine, Hydroxyzine PRN, Lorazepam PRN; MRR lacked recommendations r/t GDR of psychotropic drug use or required duration for PRN antianxiety or antipsychotic meds; Adm nurse stated due to clients facility cared for, facility did not do GDRs

NW: SS=D: Failed to ensure 1 resident was free from antipsychotic medication use w/o appropriate indication for use

- EMR documented resident with anxiety d/o, dementia, restlessness & agitation; BIMS of 14; POS for Clonazepam for "sedative" or "intoxication"; POS for Olanzapine for agitation with dementia; Adm nurse stated dx of sedation for use of Clonazepam not approved dx & Olanzapine was new order & resident had agitation with paranoia

F609 Reporting of Alleged Violations

SW: SS=D: Failed to submit completed investigation for allegations of resident-to-resident abuse to state agency within 5 working days as required for allegations involving 2 residents on 1 occasions & 2 residents on another occasion

- *Cited findings noted in F600 r/t physical & sexual behaviors on multiple occasions with multiple residents; facility could not provide investigation r/t 2 incidents & unable to provide evidence completed investigations were submitted to SA within 5 working days*

NE: SS=D: Failed to report an allegation of abuse between staff & 1 resident to State Agency (SA) as required placing resident at risk for unidentified & ongoing abuse

- *Facility's "Initial Report- Alleged Physical Altercation" investigation, not dated, documented on 08/12/25, Administrative Nurse notified Administrative Staff around 10:00 AM of allegation. Administrative Staff immediately visited resident to discuss incident. Resident reported that at approximately 03:00 AM on 08/12/25, LN attempted to wake resident up by jabbing him with a stick. Resident stated that this occurred during administration of resident's pain medication. Resident stated resident's eyes were not closed while he laid in bed at that time, & was alone in room during the incident. The investigation documented an interview with LN on 08/12/25 who stated LN did not poke resident with a stick but gently tapped resident's knee to get resident's attention. LN stated resident rolled over & took resident's medication & gave no indication of pain when LN tapped resident. LN stated LN brought resident's walker in with LN to assist resident with walking, & LN did not use walker to poke resident. The investigation documented facility reviewed video surveillance on 08/12/25 that revealed at approximately 03:06 AM, LN grabbed pills from med cart & proceeded to resident's room with resident's walker & entered resident's room with walker at 03:07:41 AM. LN exited resident's room at 03:08:26 AM with resident's walker. The video & audio surveillance did not reveal any voices or sounds heard during time LN entered resident's room. The investigation documented immediate protective actions included LN did not work during investigation, & moving forward, LN would not interact with resident or handle resident's meds; Administrative Staff stated facility did not turn resident's allegation towards LN into the SA. Adm stated that when staff reported allegation, Adm sent the information on to the regional team & immediately started investigating.*

NW: SS=D: Failed to report 1 resident's request to not be pushed by Maintenance Staff as witnessed by staff to the State Agency (SA) as Required placing resident at risk for ongoing abuse & mistreatment

- *On 07/02/25 at 12:59 PM, CNA reported on 06/05/25 that CNA witnessed Maintenance Staff pushing resident from activities, when CNA heard resident tell Maintenance Staff to stop. CNA asked resident if resident had needed anything. Resident stated, "No, I just want him gone," not in a jovial way. CNA turned to assist resident back to activities when Maintenance Staff stated, "No, I got this" & proceeded to wheel resident away from area. CNA reported to LN. CNA reported had filled out a grievance about the event & had been informed to "Let it go," but was not interviewed for what was witnessed; On 07/02/25 at 01:40 PM, Dietary Staff reported on 06/05/25, while in the dining room, staff witnessed Maintenance Staff pushing same resident around building in resident's w/c when resident requested Maintenance Staff several times to stop, because resident wanted to go to the activity room. Dietary Staff reported Maintenance Staff softly pushed resident into him & another staff member, and resident had put a foot on the ground to stop. Dietary Staff filed a grievance concern, but had not been interviewed or questioned about the occurrence; LN reported Maintenance Staff had pushed resident around facility with resident objecting, wanting to go to activity room & 3 staff had reported this & staff filled out grievance in writing & LN took it to Adm; Adm stated had been told by staff r/t grievances & reported during interview with resident, resident stated, "all fun and games" as both resident & maintenance staff had worked together at facility; Adm stated had talked to staff but had not written investigation or talked to staff individually because resident would not say wanted maintenance staff to stop or other specifics r/t occurrence & had not reported incident to State Agency (SA), nor completed written investigation r/t grievance*

F610 Investigate/Prevent/Correct Alleged Violation

SW: SS=D: Failed to thoroughly investigate allegations of abuse for allegations involving 1 resident on 2 occasions with 2 different other residents

- *Cited findings noted in F600 & F609 r/t physical & sexual behaviors between 1 resident & multiple other residents; facility unable to provide investigation r/t 2 incidents*

NW: SS=D: Failed to fully investigate an allegation of abuse for 1 resident placing resident at risk for ongoing abuse

- *Cited findings noted in F609 r/t multiple staff grievances r/t maintenance staff pushing resident around facility; Adm stated had not called SA or completed written investigation r/t staff grievance r/t resident & maintenance staff*

F627 Inappropriate Discharge

SE: SS=D: Facility initiated a 30-day involuntary discharge for 1 resident though resident's clinical record did not contain evidence to validate the reason for the involuntary discharge placing resident at risk for impaired health & well-being & involuntary discharge from facility

- *Assessment documented resident with BIMS of 15 & with verbal behavioral symptoms towards others 4-6 days & rejection of care 1-3 days during 7-day period; CO w/o discharge planning interventions; CP documented resident with behaviors including cursing, shouting/yelling during care & refusing care; NN documented resident would display a "tantrum" if resident's wishes not immediately addressed & behaviors included screaming expletives at staff, slamming hand on wall or table & kicking furniture; resident attempted to bully staff to provide skin treatments & meds that were not ordered; EMR lacked evidence of interventions attempted to address documented behaviors; NN documented resident refused to accept had smoked cigarettes & accused others of stealing cigarettes but note lacked evidence of interventions attempted to address documented behaviors; NN documented resident became angry when CNA asked resident to repeat because CNA could not hear request & resident swore at staff & threw shoe at staff & note lacked evidence of interventions attempted to address documented behaviors; NN documented resident verbally abusive to staff & another resident due to not getting breakfast fast enough & entry lacked documentation of verbal statements made to any other residents & lacked evidence of interventions attempted to address documented behaviors; multiple other behaviors documented w/o interventions; EMR lacked documentation from physician that resident's needs could not be met at facility or that resident had placed other residents in danger warranting involuntary discharge; facility unable to provide evidence of investigative reports or incident reports r/t alleged inappropriate behaviors of resident towards other residents or behaviors interventions attempted but were unsuccessful; document from LTC Ombudsman revealed letter that formally requested to withdraw involuntary discharge letter to resident due to change in circumstances; observed resident in bed asleep; Adm stated resident scheduled to be discharged home under care of daughter & family involved with planning process & family not agreeable to discharge home under care of representative; & representative refused to acknowledge resident's behavior which included sexual aggression & violence to staff; Adm stated resident had bragged about being evicted from multiple other facilities for behaviors that included fondling another resident at a different facility; Adm stated during verbal exchange between resident & another resident, resident threatened to kill other resident & no incident report because Adm did not recognize it as resident-to-resident abuse & did not report incident to state agency*

F628 Discharge Process

SE: SS=D: Failed to provide 1 resident written notification of transfer to resident/representative as soon as practicable & failed to send a copy of that notification to ombudsman; also failed to provide 1 resident/responsible party with bed hold

- Documentation noted resident admitted to hospital for observation & planned to take fluid off; EMR lacked documentation of written notification to resident/representative explaining reason for transfer to hospital & that bed hold explained & given to resident/representative; SS staff stated "forgot" to provide notice & unaware of regulation to notify resident in writing & notify Ombudsman; Adm nurse unaware of regulation to notify resident's representative in writing of discharge or transfer & facility had not been notifying ombudsman

NE: SS=D: Failed to provide a "Bed Hold Notification" for 1 resident, who was hospitalized on 02/23/25 and 03/25/25, and 1 resident's hospitalization on 06/26/25

- Resident with schizophrenia, anxiety d/o, epilepsy; NN documented resident's practitioner notified that resident had fever & change in level of consciousness & practitioner gave orders to send resident to ER; NN documented bed hold policy sent to resident's guardian; Administrative Nurse reported that bed holds were to be sent when a resident went to the hospital, but at times resident was not able to sign for themselves, or facility would call or email resident's representative; Administrative Nurse stated that verbal confirmation had not been documented, or notices were not followed up on to obtain signatures; SS stated bed hold not sent for 1 hospitalization & bed hold for other hospitalization had not been returned signed from guardian
- Record lacked that resident/representative provided written notice of transfer to hospital; SS verified resident/representative had not signed bed hold when resident transferred to hospital & had obtained provided policy verbally via phone & had documented notification in progress notes; Adm Nurse unaware facility was to provide written notice to resident/representative explaining reason for resident's transfer to hospital

F641 Accuracy of Assessments

NE: SS=D: Failed to submit a required discharge and re-entry "Minimum Data Set" for 1 resident who was hospitalized on 03/25/25 & returned to facility on 04/03/25

- EMR lacked discharge MDS for resident's admission to hospital on 3-25-25 & entry MDS on 4-3-25 when resident readmitted to facility

F655 Baseline Care Plan

SE: SS=D: Failed to complete baseline CP for 1 resident

- Baseline CP unsigned by resident/representative & lacked elopement section completed including presence of WanderGuard & SS portion of baseline CP not completed which included discharge plan & included incorrect information r/t antipsychotic med

F656 Develop/Implement Comprehensive Care Plan

NW: SS=D: Failed to develop a comprehensive CP for 2 residents who received prophylactic antibiotics for UTIs

- Resident with retention of urine, Parkinson's disease, & paranoid schizophrenia; CP lacked documentation resident had UTIs or received ABT; POS for Bactrim DS daily, prophylactic for bladder; EMR lacked documentation resident had UTI since admission; MRR did not note long-term ABT & risks associated with ongoing administration from 3-2-25 thru 10-20-25; Adm Nurse stated did not monitor prophylactic ABT with antibiotic stewardship program & would contact physician for direction on ABT & if would like to continue med
- Resident with hx of UTIs, DM, chronic pain, CHF, anxiety; CP lacked resident's hx of UTIs or long-term use of ABT; POS for Macrobid for hx of UTIs

F684 Quality of Care

SE: SS=G: Failed to provide adequate wound care for 1 resident to prevent wound from being contaminated with maggots (fly larvae leading to resident's right lower leg wound becoming contaminated with maggots, causing physical and psychosocial discomfort

- *Resident with DM II with open right lower leg wound & need for assist with personal care; resident with BIMS 15 with substantial/maximal assist with footwear; POS for wound treatment; observed resident received shower on 6-23-25 at 10:24am & dressing removed from both lower legs & maggots observed crawling on skin of both ankles & heels & staff left message with PCP & awaiting call back; at 3:11pm, PCP returned call & gave order to cleanse legs daily with Hibiclens & apply clean dressings & requested report back in 4 days & further stated maggots were "probably good for the wounds"; on 7-9-25 observed resident with both dressing saturated with unknown yellow liquid & multiple flies in room & around resident & resident able to put hands between dressings & legs; observed LN performed dressing change & both dressing saturated & falling off legs & both surveyor & LN observed maggots on right lower extremity wound & LN removed maggots from wound while performing wound care; resident stated sometimes pushed dressing down to scratch wounds & would get maggot pieces on fingers & could feel the maggots crawling in & out of skin causing discomfort from itching & making feel restless & thought maggots bothered her a bit occasionally but mainly just itchy; on 7-8-25 LN revealed dressing used to be changed every 3 days but after maggots discovered orders changed to Hibiclens & now daily; Adm Nurse & Adm unaware of continued presence of maggots; on 7-10-25 physician revealed unaware of continued existence of maggots in wound & reported facility does have fly problem that has been present in last few weeks & stated maggots in wound not harming wound or impeding wound's healing process in her professional opinion;*

F686 Treatment/Services to Prevent/Heal Pressure Ulcer (PU)

SW: SS=G: Failed to prevent development of facility-acquired PUs on 1 resident's right & left buttock when staff failed to adequately monitor wounds after initial development including measurements, presence of infection, drainage & effectiveness of treatments, failed to implement routine repositioning in the bed & w/c until after wounds progressed, & did not implement standard interventions such as low air loss mattress until after PUs worsened. The facility did not immediately implement nutritional interventions to address wound prevention or healing. As a result, resident developed facility-acquired Stage 3 PU & placed resident at risk for development of new PUs & delayed healing & worsening of existing ulcers

- *Resident at risk for skin impairment; not on turn & reposition schedule; EMR "Tasks" lacked turn & repositioning program; NN documented resident's representative called & informed nurse that resident told rep that resident had wound on coccyx & nurse informed rep that no new wounds were reported & nursing would follow up; POS for wound care same day as rep call; MAR/TAR lacked evidence staff administered tx; multiple other POS tx's ordered; 3-5-25 documented wound open & note lacked evidence of physician notification; multiple Weekly Skin Data Collection Tool lacked measurements, assessment of peri-wound, presence of drainage or signs of infection; multiple changes lacked documentation of physician notification; wound care provider consultant included in cares; resident admitted to hospital for potential sepsis, wound debridement & change in condition; Adm nurse stated had not completed wound assessments on resident as person who trained did not correctly train, so gap of no wound assessments completed*

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=D (Past Non-Compliance): Failed to ensure that staff placed & secured 1 resident's w/c & safety belt properly used in facility's transportation van prior to engaging vehicle to drive resulting in w/c overturning, & resident fell from w/c placing resident at risk of injury & likely harm

- *NN documented resident reported to nurse that had fall previous day on bus & was now having pain & swelling in hand; nurse notified provider & order received for X-ray; investigation documented staff buckled resident in & when turned corner resident's w/c fell over to side; staff then pulled vehicle over to different parking lot & stopped & got resident out of w/c & lifted resident back up into chair; staff documented resident was over on side of bus & had to bring seat belt from other side of bus over to buckle resident in due to resident being adamant about sitting on left side of bus; X-ray revealed no acute injury; intervention was education & training provided to transport drivers on securing w/c in van & CP updated; records revealed "involuntary termination" of staff for failure to notify Adm or DON of resident fall; internal investigation discovered that resident's w/c was secured but not in appropriate placement in van; staff stated thought honoring resident's rights when refused to move & did the best could with securing w/c in place that resident chose to sit; resident stated accident not driver's fault & stated wanted to sit on left side of van & driver made sure he was seat-belted in; assessment documented resident's left hand was hurting, swollen & bruised*
- *Plan of Removal:*
    - *Education to staff who were vehicle drivers on policies/procedures, safety checklist, competency checklist, video demonstration on how to properly secure w/c's during transport, & staff demonstrated competency prior to onsite survey so deemed past noncompliance & remained at D*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NW: SS=D: Failed to notify physician r/t issues with red drainage from urinary catheter & lack of urine output for night shift for 1 resident, placing resident at risk for physical decline & UTIs

- *EMR documented resident with urinary retention, BPH, chronic kidney disease with catheter; NN documented resident c/o pain & little urine output; staff attempted to flush catheter with no relief, attempted to advance catheter with no output & removed water from balloon; catheter removed & large amount of dark red drainage came out; staff changed catheter that immediate cloudy yellow return then inflated bulb & resident stated felt better but red drainage continued; EMR lacked documentation that physician or responsible party notified lack of urine output or red drainage; NN documented resident with emesis & nausea; staff notified physician of change in condition r/t drowsiness, difficult to arouse & vital signs on lower end & urine output/color & physician directed to send resident to ER & admitted to regional hospital for UTI*

F725 Sufficient Nursing Staff

NE: SS=F: Failed to have sufficient licensed nursing staff 24 hours a day

- Review of LN record with employment date of 9-25-23 & verification revealed LN's license had lapsed on 6-30-25 & LN had worked on 20 days in July, 16 days in August, 18 days in September, & 8 days in October, 2025; Adm nurse stated LN must not have been responsible enough to have gotten renewal process completed

F727 RN 8 Hrs/7 days/Wk, Full Time DON

NW: SS=F: Failed to provide RN coverage for 8 consecutive hours a day, 7 days a week

- PBJ documented facility lacked RN 8-hr coverage for 4 days from 4-19-25 thru 5-24-25; Adm nurse verified no RN in LTC unit but there was an RN on-call; Adm stated report run after accounts payable received timesheet & there were times when did not get

agency staff timesheets before submitting PBJ so that was probably a "glitch" & had now changed systems & agency staff can clock in to track time better

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to ensure posted daily nurse staffing sheets included accurate & identifiable information to include daily licensed & unlicensed staff actual hours

- Daily Staffing sheets did not include actual hours worked, total hours worked for nurses & CMA/CNA for 7 consecutive days in August, 2025; observed daily staffing sheet not posted on 1 day of survey; 1 day of survey only listed total hours worked, & actual hours not listed

F740 Behavioral Health Services

NE: SS=J (Plan of Removal to G): Failed to provide necessary behavioral care & services for 1 resident who had moderate cognitive impairment as well as schizophrenia, depression, & history of violence & substance abuse

- *On 07/07/25, R1 began refusing to take his mental health meds& demonstrated increased behaviors. On 07/10/25, around 11:06 AM, the Social Worker spoke with resident's parental guardian, who shared concerns with resident's history of medication noncompliance, erratic behaviors, & history of substance abuse. At around 03:58 PM, after asking Administrative Nurse D & Administrative Nurse E a question, resident began kicking the door, stating he wanted to leave the facility, & made threats to kill the staff. The staff provided resident with an Against Medical Advice (AMA) form which resident signed, and allowed resident to leave the facility. The staff did not involve resident's physician, guardians, emergency services, or law enforcement in an attempt to de-escalate or address the mental health crisis. Resident was gone from the facility, with his whereabouts unknown, for seven days before law enforcement picked him up for attempting to procure alcohol without payment & for erratic behaviors. Resident admitted to the acute hospital with sunburn & dehydration. The facility's failure to provide adequate & appropriate services, including physician & guardian involvement to treat a behavioral health crisis, placed resident in immediate jeopardy*
- *Plan of Removal:*
  - *Adm Nurse re-educated staff that administered med on facility "Notification of Changes" policy to include notification to physician & guardian/responsible party upon refusal of meds*
  - *Began audit process for refusal of meds for appropriate notifications to physician & guardian/responsible party daily x 4 weeks*
  - *Regional Nurse Consultant re-educated IDT & professional nursing staff on facility "Transfer & Discharge" policy, including AMA process*
  - *Regional VP &/or Regional Nurse Consultant will be notified prior to any resident leaving AMA to ensure facility processes were followed*

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=E: Failed to ensure Consultant Pharmacist (CP) ID'd & reported irregularities to attending physician, facility medical director, & DON for 4 residents

- Cited findings noted in F605 r/t lack of CP recommendations for GDRs & stop dates for PRN psychoactive meds

NW: SS=D: Consultant Pharmacist (CP) failed to address with facility ongoing prophylactic ABT use for 2 residents

- Cited findings noted in F656 r/t 2 residents receiving prophylactic long term ABT;CP's MRR did not note long-term ABT use or risks associated with ongoing administration from 3-2025 thru 10-2025 for 1 resident & pharmacist had not alerted facility to prophylactic ABT used on MRRs for resident

F761 Label/Store Drugs & Biologicals

NE: SS=D: Failed to ensure meds & biologicals for residents were not outdated

- Observed Nystatin Cream with expired dated

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to store & prepare food under sanitary conditions for residents of facility

- Observed fridge with multiple opened, unlabeled bags of produce, condiments w/o label for date opened
- Kitchen with unsanitizable countertop with exposed wood at corner; metal entrance door with missing paint around handle of door; handwashing sink with loose caulking at junction of sink to wall & brown staining noted in area behind loose caulking adjacent to wall; stack of cookie sheets with baked-on brown grime inside on cooking surface & outside of sheet; gas stove with grease build up on outer ridge around hood above stove
- Observed 2 CNAs entered food prep area w/o washing hands, picked up lates of food then delivered plates to several resident, touching 1 resident's back then returned to kitchen w/o performing hand hygiene & repeating process including picking up condiments & placing them direction on top of plated food

NE: SS=F: Failed to store, prepare, distribute, & serve food by professional standards for food service safety in 1 kitchen

- Observed fridge with expired food item; observed SS walked into kitchen by prep area w/o hair net, took a plate of food from CNA & delivered it to resident at DR table; observed freezer with unlabeled & undated meat patties & freezer with ½ to 1 inch ice buildup on inside top

F849 Hospice Services

NW: SS=D: Failed to provide thorough CPing instruction for 1 resident who received Hospice services

- Hospice services included hospice phone number but lacked name of hospice, what supplies would be provided, & how often hospice staff would assess & provide care for resident

F851 Payroll Based Journal

NW: SS=C: Failed to submit complete & accurate staffing information through CMS

- PBJ reports for quarter 2 indicated no LN coverage for 4 days & quarter 3 recorded no LN coverage for 3 dates; payroll data revealed LN was on duty for 24 hrs/day, 7 days/wk; Adm stated report run after accounts payable received timesheet & there were times when facility did not get agency staff timesheets before submitting PBJ, so probably a glitch & have since changed systems & agency staff can clock in to track time better

F880 Infection Prevention & Control

SE: SS=E: Failed to maintain an effective infection control program r/t inadequate hand hygiene during wound care & inadequate cleaning of furniture with potential to spread possible infections to residents in facility

- *Cited findings noted in F584 r/t recliner chair saturated in recliner, strong urine odor & chair remained uncleaned for several minutes & then housekeeping staff stated did not use any chemicals for cleaning urine-soaked chair*
- *Observed LN entered resident's room & donned gloves & gown w/o performing hand hygiene then performed wound care & failed to change gloves or perform hand hygiene after removing soiled dressings & starting new dressing then changed gloves w/o hand hygiene then performed wound care on other leg & failed to perform hand hygiene after removing gloves between soiled & clean dressing*

SE: SS=D: Failed to implement adequate & acceptable infection control practices when staff did not disinfect a glucometer after use

- Observed LN performed blood glucose check on 1 resident & after completion, LN returned to office & did not clean or disinfect glucometer; LN verified did not usually clean glucometer unless there was blood on it or it was dirty

NE: SS=F: Failed to implement EBP to reduce the spread of MDROs for 1 resident who had indwelling urinary catheter; also failed to implement water management program for Legionella disease

- Resident with suprapubic urinary catheter; CP lacked information r/t EBP; resident's room lacked EBP signage or had gown or gloves stored in room; observed CNA perform catheter emptying & donned gloves, performed emptying, then removed gloves & did not wear gown during process; Adm nurse stated unaware of EBP requirements & staff used standard precautions
- Upon request Adm staff stated unaware of requirement for waterborne pathogen/Legionella program & did not have system in place for it

F881 Antibiotic Stewardship Program

NE: SS=D: Failed to implement protocols to avoid unnecessary &/or inappropriate ABT use, adverse events & MDRO & to assess for infection using standardized tools & criteria before ABT

- Administrative Nurse stated the facility had not utilized a standardized criteria tool before antibiotics were ordered, nor a stop & watch system, & was unsure what McGeer's criteria were. Administrative Nurse stated staff reported signs & symptoms to physicians, & occasionally, physician would obtain a culture for UTIs & would change antibiotic if needed. Administrative Nurse stated physician would generally order a broad-spectrum antibiotic to ensure infectious process was covered by causing microorganism

NW: SS=D: Failed to implement antibiotic use protocols to avoid unnecessary &/or inappropriate antibiotic use to reduce the risk of adverse effects, including antibiotic resistance, when facility failed to monitor effectiveness & evaluate appropriateness for extended administration of prophylactic antibiotics for 2 residents

- Cited findings noted in F656 & F756 r/t prophylactic ABT therapy for 2 residents & Adm nurse stated did not track prophylactic ABT

F925 Maintains Effective Pest Control Program

SE: SS=E: Failed to ensure effective pest control in facility placing affected residents of facility at risk for decreased health & wellness

- *Cited findings noted in F684 r/t multiple flies in facility & maggots in 1 resident's wound; observed 1 resident room with multiple flies in room & fly paper strip hanging from ceiling in room next to closet; observed multiple flies on multiple occasions & no evidence of any fly mitigation attempts; Adm nurse stated facility had been concerned about flies for "awhile" & Adm had been implementing fly mitigation strategies; Adm stated had installed fly paper strips w/o success & had ordered "fly bags" & had arrived but had not been installed & flies due to mostly rural area & prevalence of cattle in area*