

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175425	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER SPRING HILL CARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 251 E WILSON AVENUE SPRING HILL, KS 66083		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 550 SS=D	The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in KS00195635. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with five reviewed for dignity. Based on observation, record review, and interviews, the facility failed to provide a dignified care environment for Resident (R) 20. This deficient practice placed R20 at risk for impaired dignity and unmet care needs. Findings Included: - The "Medical Diagnosis" section within R20's Electronic Medical Records (EMR) included diagnoses of benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's "Quarterly Minimum Data Set (MDS)" dated 04/15/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated he used a walker for mobility. The MDs noted he was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS	F 550			

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F 550	Continued From page 2 noted he was always incontinent of bowel and bladder, but had a toileting program. The MDS noted he had difficulty swallowing due to holding residual food in his mouth (pocketing). The MDS noted he had a mechanically altered diet. R20's "Nutrition Care Area Assessment (CAA)" completed 01/27/25 indicated he was at risk for weight loss and nutritional impairment. The CAA instructed staff to provide adequate intake during mealtimes. The CAA noted he was on a mechanically altered diet with thin liquids. R20's "Functional Abilities CAA" completed 01/27/25 indicated he required cueing during his activities of daily living (ADL) and incontinence care every two hours. R20's "Care Plan" initiated 03/08/22 indicated he was at risk for altered nutrition related to his cognitive impairment and medical diagnoses. The plan instructed staff to provide set-up assistance during meals. The plan indicated he required staff assistance for bed mobility, bathing, toileting, personal hygiene, transfers, and dressing. The plan indicated he had impaired cognitive function and thought processes related to his dementia. The plan instructed staff to provide consistency with caregivers and care to reduce confusion. The plan instructed staff to notify nursing if incontinent during activities and provide care as needed. On 06/10/25 at 09:00 AM, R20 sat in the dining room and completed his breakfast meal. R20 stood up and walked toward the dining room exit. The back of R20's pants were soaked with urine down to his knees. R20 walked to the staff and reported he was sticky and needed to be cleaned.	F 550			

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F 550	Continued From page 3 Staff asked R20 to sit on the chair next to the nurses. R20 sat down in the chair next to the nurse's cart. R20 kept repeatedly saying loudly "I'm sticky, I need help" as numerous staff walked past him. R20 stood up from the chair several times while waiting for staff to come assist him. At 09:10 AM, R20 was finally escorted to his room as he continued to yell out "I'm sticky, please help me". On 06/11/25 at 11:20 AM, Certified Nurse Aide (CNA) M stated staff should always assist the resident with care needs as a priority and ensure they were clean. She stated that R20 should have been provided with hygiene care immediately. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated residents should immediately provide incontinence care to avoid skin breakdown and infections. On 06/11/25 at 12:24 PM, Administrative Nurse D stated staff were expected to assist or find someone to assist residents with personal care to prevent them from waiting. She stated residents were to be provided incontinence care at the time of staff being informed. The facility's "Dignity" policy revised 10/2022 stated the facility was to ensure an environment that maintained and enhanced each resident's dignity and respect in full recognition of each resident's individuality.	F 550			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600			

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F 600	Continued From page 4 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with one resident reviewed for abuse and neglect. Based on observation, record review, and interview, the facility failed to prevent an episode of resident-to-resident sexual abuse between cognitively impaired Resident (R) 21 and R17. This deficient practice placed R17 at ongoing risk for preventable abuse and mistreatment. Findings Included: - The "Medical Diagnosis" section within R21's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, repeated falls, and the need for assistance with personal care. R21's "Annual Minimum Data Set (MDS)" dated 04/27/25 noted a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. The MDS indicated she had bilateral lower extremity impairments and used a	F 600			

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F 600	Continued From page 5 wheelchair for mobility. The MDS indicated he was dependent on staff for bathing, toileting, personal hygiene, transfers, and bed mobility. The MDS indicated no behavioral concerns but indicated he displayed physically aggressive behaviors on his previous "Quarterly MDS" completed 01/27/25. R21's "Dementia Care Area Assessment (CAA)" completed 01/27/25 indicated he was dependent on staff assistance for toileting, personal hygiene, bathing, dressing, and transfers. The CAA noted he had dementia with cognitive loss. R21's "Care Plan" initiated on 10/04/23 indicated he was at risk for a decline in cognition, activities of daily living (ADL), falls, and incontinence related to his medical diagnoses. The plan indicated he required staff assistance for mobility in his wheelchair (10/03/23). The plan indicated he had difficulty with communication. The plan instructed staff to be conscious of his position when in groups, activities, and dining to promote proper communication with others (10/03/23). The plan noted he had a history of alleged sexual accusations (10/03/23). The plan instructed staff to anticipate his needs and provide his medications as ordered (10/03/23). The plan instructed staff to intervene as necessary to protect the rights and safety of others (10/04/23). The plan instructed staff to move him from the situation to an alternate area. The plan instructed staff to monitor his behaviors and attempt to determine an underlying cause (10/04/23). R21's plan was updated on 05/27/25 with a new intervention for sexual behaviors. The intervention instructed staff to provide medication daily.	F 600			

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F 600	Continued From page 6 A "Facility Incident Report #5635" completed on 05/27/25 revealed Licensed Nurse (LN) H walked into the television room and witnessed R21 in the television room groping R17's (Severely cognitively impaired resident) breast. The report indicated both residents were immediately separated. The note revealed that R17 was assessed with no injuries found. The report indicated both residents had no recollection of the incident when interviewed. The note revealed the medical provider, resident representative, and local law enforcement were notified. The report revealed that R21 was immediately placed on one-to-one supervision and started on medication to reduce his sexual behaviors. A "Witness Statement" completed by LN H on 05/27/25 indicated he observed the incident and separated the two residents. LN H reported in the statement he observed R21 touching R17's breast with his left hand. LN H reported in the statement that he immediately separated the residents and assessed R17. The statement revealed that R21 was agitated when asked to not touch R17. On 06/10/25 at 07:30 AM, R21 lay in his bed. R21 had no memory of the encounter between R17 and himself. On 06/11/25 at 08:00 AM, R17 sat in her room. R17 had no memory of the encounter between R21 and herself. R17 reported she felt safe in the facility. On 06/11/25 at 11:24 AM, Certified Nurse's Aide (CNA) M stated residents with noted behaviors were not to be left alone with other residents. She stated staff were expected to monitor all residents	F 600			

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F 600	Continued From page 7 for safety and care needs. She stated that R21 had a history of inappropriate behaviors towards females and had to be supervised. She stated the facility provided frequent dementia and abuse training for staff to complete. She stated the facility had an abuse, neglect, and exploitation (ANE) class in May 2025. On 06/11/25 at 12:24 PM, Administrative Nurse D stated R21 had inappropriate sexual behaviors toward a female. She stated residents with behaviors were to be supervised while in the common areas or placed close together. She stated that R21 had numerous behavioral incidents in the past. She stated all staff received annual ANE classes. The facility's "Abuse Prevention Program" revised 08/2024 indicated the facility was committed to protecting residents from abuse. The policy indicated all staff were trained to recognize and report allegations of abuse. The policy noted the facility was to provide management for dementia and behavioral symptoms for residents at risk for abuse. The policy indicated the facility promoted an environment safe for the treatment and care of the residents.	F 600			
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3) (d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or	F 605			

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F 605	Continued From page 8 convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 605			

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F 605	Continued From page 9 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 605			

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F 605	Continued From page 10 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1's psychotropic (alters mood or thought) medication had an indication for administration. This deficient practice placed R1 at risk for ineffective treatment, unnecessary medication use, and unwarranted side effects. Findings included: - R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (HTN - elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), calculus (a hardened deposit, usually composed of mineral salts, that forms within the body) of the gallbladder, and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The "Annual Minimum Data Set (MDS)" dated 09/19/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had received anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of	F 605			

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F 605	Continued From page 11 medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, diuretic (a medication to promote the formation and excretion of urine) medication, opioid (a class of controlled drugs used to treat pain) medication, and hypoglycemic (a class of medication used to lower blood sugar) medication during the observation period. The "Quarterly MDS" dated 02/20/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R1 had received anticoagulant medication, antidepressant medication, antianxiety medication, antiplatelet medication, diuretic medication, opioid medication, and hypoglycemic medication during the observation period. R1's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)" dated 10/07/24 documented she received anticoagulant therapy and psychotropic medications with monitoring in place. R1's "Care Plan," dated 10/28/22, documented staff were educated on the administration of giving medication as ordered and the five rights of medication administration. R1's EMR under the "Orders" tab revealed the following physician orders: Cymbalta (antidepressant) oral capsule, delayed release particles, 20 mg give one capsule by mouth daily, dated 04/22/25. The medication order lacked an indication for administration.	F 605			

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F 605	Continued From page 12 On 06/10/25 at 08:26 AM, R1 propelled herself in her wheelchair from her room to the dining room without difficulty. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated every medication required an indication for administration. LN G stated she would clarify an order if there was no indication for administration. On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected a physician's order to be followed. Administrative Nurse D stated every medication required and indication for administration. The facility's "Free from Chemical Restraints, Unnecessary Psychotropic Medications" policy last reviewed 04/2025 documented chemical restraints would only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Chemical restraints would only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience.	F 605			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the	F 636			

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F 636	Continued From page 13 resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.	F 636			

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F 636	Continued From page 14 (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to indicate on the comprehensive Minimum Data Set (MDS) that Resident (R) 33 received and required the use of a continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). This placed R33 at risk for inaccurate reflections of the resident's status and needs to develop an individualized comprehensive plan of care. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of acquired absence of right foot, pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral region, hematogenous osteomyelitis (a type of bone infection where bacteria travel through the bloodstream to the bones, causing inflammation and potentially bone destruction), lack of coordination, muscle weakness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).	F 636			

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F 636	Continued From page 15 The "Admission Minimum Data Set" (MDS) dated 04/21/25 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R33 had impairment on one side of her lower extremities. The MDS documented R33 needed setup or cleanup for eating, was dependent on staff for toileting, and needed substantial/maximal assistance from staff for bathing. The MDS did not indicate R33 required the use of a CPAP. R33's "Functional Abilities (self-care mobility) Care Area Assessment" (CAA) dated 04/21/25 documented R33 was currently taking insulin (a hormone that lowers the level of glucose in the blood), antihypertensive (a class of medication used to treat high blood pressure), anticoagulation (blood thinner), and medication for constipation which could cause an increase in falls. The CAA documented R33 had had no falls since admission. The CAA documented R33 was dependent on staff for most activities of daily living (ADL) and required the assistance of one staff. The CAA documented R33 ambulated with a wheelchair and was dependent on staff for wheeling her chair. The CAA documented R33 currently received medication for wound healing. The CAA documented R33 was on a regular diet, with regular texture with thin liquids. The CAA documented R33 was incontinent and required a pull-up. R33's "Care Plan" dated 04/18/25 documented R33 was at risk for altered nutritional and hydration status related to inadequate intake and wound healing. R33's plan of care documented staff would encourage the consumption of fluids	F 636			

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F 636	Continued From page 16 that were provided and monitor and record meal intakes. The plan of care for R33 documented staff would provide and serve supplements as ordered. R33's plan of care lacked indication of R33's CPAP. On 06/11/25 at 12:05 PM, Administrative Nurse D stated that R33 required a CPAP. Administrative Nurse D stated all CPAPs should be indicated on the MDS. The facility "Comprehensive Assessment" dated 03/25 documented a comprehensive assessment of a resident's needs shall be made within fourteen days of the resident's admission. A comprehensive assessment of the resident's needs strengths, goals, life history, and preferences would be completed. A comprehensive assessment would be completed with defined significant change. Residents would receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline.	F 636			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656			

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F 656	Continued From page 17 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with five reviewed for care plan revisions. Based on	F 656			

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F 656	Continued From page 18 observation, record review, and interviews, the facility failed to revise Resident (R) 20's "Care Plan" to remove his therapeutic diet. This deficient practice placed R20 at risk for uncommunicated care needs. Findings Included: - The "Medical Diagnosis" section within R20's Electronic Medical Records (EMR) included diagnoses of benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's "Quarterly Minimum Data Set (MDS)" dated 04/15/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated he used a walker for mobility. The MDs noted he was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS noted he was always incontinent of bowel and bladder but had a toileting program. The MDS noted he had difficulty swallowing due to holding residual food in his mouth (pocketing). The MDS noted he had a mechanically altered diet. R20's "Nutrition Area Assessment (CAA)" completed 01/27/25 indicated he was at risk for weight loss and nutritional impairment. The CAA instructed staff to provide adequate intake during mealtimes. The CAA noted he was on a mechanically altered diet with thin liquids.	F 656			

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F 656	Continued From page 19 R20's "Functional Abilities CAA" completed 01/27/25 indicated he required cueing during his activities of daily living (ADL) and incontinence care every two hours. R20's "Care Plan" initiated 03/08/22 indicated he was at risk for altered nutrition related to his cognitive impairment and medical diagnoses. The plan indicated he required a regular, mechanically soft diet with pureed meat texture and thin liquids due to his difficulty swallowing. The plan instructed staff to provide set-up assistance during meals. The plan indicated he required staff assistance for bed mobility, bathing, toileting, personal hygiene, transfers, and dressing. The plan indicated he had impaired cognitive function and thought processes related to his dementia. The plan instructed staff to provide consistency with caregivers and care to reduce confusion. The plan instructed staff to notify nursing if R20 was incontinent during activities and provide care as needed. R20's EMR under "Orders" revealed an active dietary order stated 05/21/25. The order indicated he received a regular, mechanically soft diet with chopped meat texture. On 06/10/24 at 12:23 PM, R20 sat at the dining room table for lunch. R20 was provided his meal. R20's meat was of chopped consistency. R20 consumed his meal with no observed swallowing concerns. Staff supervised him as he ate his meal. On 06/09/25 at 11:36 AM, Licensed Nurse (LN) G stated the care plans were updated quarterly or changed. She stated the plans were to reflect to	F 656			

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F 656	Continued From page 20 most accurate changes related to each resident's care. She stated the plan should include the type of diet and consistency for each resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all staff had access to view the care plans. She stated the plans were reviewed by the interdisciplinary team and updated when needed. She stated the individual departments would also review the plan to ensure their areas were accurate and up to date. The facility's "Comprehensive Care plan" policy revised 04/2022 indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657			

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F 657	Continued From page 21 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with five reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 20's "Care Plan" to remove his therapeutic diet. This deficient practice placed R20 at risk for uncommunicated care needs. Findings Included: - The "Medical Diagnosis" section within R20's Electronic Medical Records (EMR) included diagnoses of benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's "Quarterly Minimum Data Set (MDS)" dated 04/15/25 noted a Brief Interview for Mental Status	F 657			

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F 657	Continued From page 22 (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated he used a walker for mobility. The MDs noted he was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS noted he was always incontinent of bowel and bladder but had a toileting program. The MDS noted he had difficulty swallowing due to holding residual food in his mouth (pocketing). The MDS noted he had a mechanically altered diet. R20's "Nutrition Area Assessment (CAA)" completed 01/27/25 indicated he was at risk for weight loss and nutritional impairment. The CAA instructed staff to provide adequate intake during mealtimes. The CAA noted he was on a mechanically altered diet with thin liquids. R20's "Functional Abilities CAA" completed 01/27/25 indicated he required cueing during his activities of daily living (ADL) and incontinence care every two hours. R20's "Care Plan" initiated 03/08/22 indicated he was at risk for altered nutrition related to his cognitive impairment and medical diagnoses. The plan indicated he required a regular, mechanically soft diet with pureed meat texture and thin liquids due to his difficulty swallowing. The plan instructed staff to provide set-up assistance during meals. The plan indicated he required staff assistance for bed mobility, bathing, toileting, personal hygiene, transfers, and dressing. The plan indicated he had impaired cognitive function and thought processes related to his dementia. The plan instructed staff to provide consistency with caregivers and care to reduce confusion. The plan instructed staff to notify nursing if incontinent during activities and provide care as	F 657			

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F 657	Continued From page 23 needed. R20's EMR under "Orders" revealed an active dietary order stated 05/21/25. The order indicated he received a regular, mechanically soft diet with chopped meat texture. On 06/10/24 at 12:23 PM, R20 sat at the dining room table for lunch. R20 was provided his meal. R20's meat was of chopped consistency. R20 consumed his meal with no observed swallowing concerns. Staff supervised him as he ate his meal. On 06/09/25 at 11:36 AM, Licensed Nurse (LN) G stated the care plans were updated quarterly or changed. She stated the plans were to reflect the most accurate changes related to each resident's care. She stated the plan should include the type of diet and consistency for each resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all staff had access to view the care plans. She stated the plans were reviewed by the interdisciplinary team and updated when needed. She stated the individual departments would also review the plan to ensure their areas were accurate and up to date. The facility's "Comprehensive Care Plan" policy revised 04/2022 indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677			

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F 677	Continued From page 24 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with one resident reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 9 with assistance with eating and further failed to ensure R9's call light was within his reach. This defiant practice placed R9 at risk of aspiration and unmet needs. Findings included: - R9's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebrovascular accident (CVA-stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) effecting left non-dominant side, pulmonary edema (accumulation of extravascular fluid in the lung tissues), pain, obesity (excessive calories), dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), sleep apnea (a disorder of sleep characterized by periods without respirations), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), contracture (abnormal permanent fixation of a joint or muscle) left hand, elbow and	F 677			

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F 677	Continued From page 25 shoulder, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and respiratory failure with hypoxia (occurs when the lungs were unable to adequately provide oxygen to the bloodstream, leading to low oxygen levels in the blood). The "Significant Change Minimum Data Set" (MDS) dated 01/24/25 documented a Brief Interview of Mental Status (BIMS) should not be conducted, and that R9 was rarely or never understood. MDS documented R9 was dependent on staff for all activities of daily living (ADL) except eating and needed setup or cleanup from staff. The MDS documented R9 had impairment on one side of his upper body, and both sides of his lower body. R9's " Functional Abilities (Self-Care Mobility) Care Area Assessment" (CAA) dated 01/24/25 documented R9 required supervision while eating related to being on a mechanically altered diet. The CAA documented R9 could feed himself and required set-up and clean-up assistance. R9 was dependent on staff for all care, hygiene, toileting hygiene, wheeling the wheelchair, bathing, dressing the upper and lower body, and applying footwear. The resident currently had shown a decline in ADLs and had chosen Hospice services. R9's "Care Plan" dated 01/14/25 documented R9 preferred to eat in his room, and R9 preferred to stay in his room most of the time. R9's plan of care documented on 09/16/24 R9 spilled hot water on himself. R9's plan of care dated 07/15/24 documented R9 required supervisor/touching assistance with eating. R9's plan of care documented R9 used a trapeze	F 677			

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F 677	Continued From page 26 above his bed to assist in repositioning, and staff were to maintain the call bell within his reach. R9's EMR under "Orders" documented the following physician's order: Elevate the head of bed thirty-fourty-five degrees to prevent/treat shortness of breath while he laid in bed every shift for respiratory failure and pulmonary edema, dated 09/23/23. On 06/09/25 at 09:34 AM, R9 was laid flat in his bed on his back. R9 had a bowl of oatmeal trying to spoon the oatmeal to his mouth. R9's call light was wrapped around his trapeze arm, out of R9's reach. R9 had no staff assistance in his room to help or monitor his eating. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated call lights should always be within the resident's reach. LN G stated all residents should be raised as high as the resident could be when eating alone in their bed. She stated a resident's bed should never be laid flat when a resident was eating. On 06/11/25 at 11:53 AM, Certified Nurse Aide (CNA) M stated the CNAs and sometimes kitchen staff delivered meals to the residents' rooms. CNA M stated residents should not be laid flat when they are eating. She stated call lights should always be laid on the resident or where the resident could reach it if needed. On 06/11/25 at 12:05 PM, Administrative Nurse D stated resident's bed should be elevated when a resident was eating in bed, never laid flat. Administrative Nurse D stated call lights should be within the resident's reach.	F 677			

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F 677	Continued From page 27	F 677			
F 686 SS=D	The facility's "Quality of Life" policy dated 04/25 documented the community environment and staff behaviors were directed toward assisting the resident in maintaining and or achieving independent functioning dignity and well-being. Residents who were unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition grooming and personal and oral hygiene. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with three reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R) 27's pressure-reducing low air-loss	F 686			

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F 686	Continued From page 28 mattress (specialized air mattress used to reduce the pressure applied to the body) was utilized per her weight and manufacturer's safe use recommendations. The facility additionally failed to apply R9's pressure-reducing boots, which were used to off-load the heels of his feet per his care plan. These deficient practices placed both residents at risk for preventable wounds and impaired wound healing. Findings included: - The "Medical Diagnosis" section within R27's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), muscle failure, and kyphosis (abnormal spinal curvature in the upper back). R27's "Annual Minimum Data Set (MDS)" dated 03/27/25 noted a Brief Interview for Mental Status (BIMS) score of 13, indicating mild cognitive impairment. The MDS noted she required partial to moderate assistance from staff for bed mobility, transfers, bathing, dressing, toileting, and personal hygiene. The MDS noted she was at risk for developing a pressure ulcer. The MDS noted she had no unhealed pressure ulcers. The MDS noted she had pressure-relieving devices for her wheelchair and bed. R27's previous "Quarterly MDS" completed 02/08/25 noted she had an unhealed stage-two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure injury. R27's "Pressure Ulcer Care Area Assessment (CAA)" completed 03/25/25 indicated she was at risk for skin breakdown and pressure ulcers related to her limited mobility, history of pressure ulcers, and medical diagnoses. The CAA noted	F 686			

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F 686	Continued From page 29 the facility would implement care-planned interventions to minimize the risks. R27's "Care Plan" initiated 05/27/24 indicated she had activities of daily living (ADL) self-care deficit. The plan indicated she required partial to moderate assistance from staff for toileting, bathing, transfers, bed mobility, dressing, and personal hygiene. The plan indicated she had bladder incontinence and was at risk for skin impairments. The plan instructed staff to provide a two-hour incontinence check and skin monitoring. The plan lacked documentation related to her risks for pressure ulcers or the use of her low air-loss mattress. R27's EMR under "Assessments" revealed a "Braden Scale" assessment completed on 03/28/25. The assessment revealed a score of 11 indicating she was at high risk for the development of pressure ulcers. R27's EMR under "Weekly Skin Evaluation" revealed she had a reddened area on her thoracic spine area (mid-back spine) that was resolving. R27's EMR under "Vitals" revealed she weighed 86.1 pounds (lbs.) on 06/04/25. A review of the low air-loss mattress manufacturer's operation (ProActive Protekt Aire 6000) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range selected. The manual revealed that using the mattress while deflated placed the resident at	F 686			

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F 686	Continued From page 30 risk for injuries. On 06/09/25 at 08:21 AM, R27 sat in her bed. The head of her bed was raised above 45 degrees as she ate her breakfast. R27's low air-loss mattress was set to 180 lbs. The mattress pump had fixed weight settings of 80lbs, 130lbs, 180lbs, 230lbs, 280lbs, 340lbs, 400lbs, and 450lbs. On 06/10/24 at 10:11 AM, R27 slept in her bed. Her mattress pump was set to 180lbs. On 06/11/25 at 10:32 AM, R27 sat in her bed as she colored in her sketchbook. She sat upright with the head of her bed raised over 45 degrees. R27's air mattress was deflated, and the low air-loss control panel was off. R27 sat directly on the frame of the bed. She stated she was not sure how long the bed was off but thought staff turned it back on when she left the room earlier in the morning. On 06/11/25 at 10:34 AM, Certified Medication Aide (CMA) entered the room and checked the bed control. She turned the panel on and stated she was not sure why the panel was off. She stated staff were expected to check the bed each shift and set it to R27's weight. On 06/11/25 at 12:05 PM, Administrative Nurse D stated the low air-loss mattresses were to be set according to the resident's weight and checked each time staff entered the room. The facility's "Prevention of Pressure Injuries" policy revised 08/2022 indicated the facility was to identify and implement preventative interventions for residents at risk for pressure injuries. The	F 686			

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F 686	Continued From page 31 policy indicated the facility was to implement and provide ongoing monitoring for wound care and preventative services to ensure effective treatment and wound prevention. - R9's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebrovascular accident (CVA-stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) effecting left non-dominant side, pulmonary edema (accumulation of extravascular fluid in the lung tissues), pain, obesity (excessive calories), dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), sleep apnea (a disorder of sleep characterized by periods without respirations), contracture (abnormal permanent fixation of a joint or muscle) of left hand, elbow and shoulder, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and respiratory failure with hypoxia (occurs when the lungs were unable to adequately provide oxygen to the bloodstream, leading to low oxygen levels in the blood). The "Significant Change Minimum Data Set" (MDS) dated 01/24/25 documented a Brief Interview of Mental Status (BIMS) should not be conducted. The MDS documented R9 was rarely or never understood. The MDS documented R9 was dependent on staff for all activities of daily living (ADL) except eating and needed setup or cleanup. The MDS documented R9 had impairment on one side of his upper body, and both sides of his lower body.	F 686			

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F 686	Continued From page 32 R9's " Pressure Injury/Ulcer Care Area Assessment" (CAA) dated 01/24/25 documented R9 was always incontinent of both bowel and bladder. The CAA documented R9 required assistance with all care. The CAA documented R9 was seen by the wound physician weekly, with daily dressing changes. The CAA documented R9 was admitted to Hospice services. R9's "Care Plan" dated 04/05/23 documented R9 had a low air loss mattress with bolsters, staff were to check low air loss mattress for proper setting according to R9's weight. R9's plan of care documented R9 had a pressure-reducing wheelchair cushion. R9's plan of care dated 06/23/24 documented R9 had a potential and actual impairment to skin integrity related to immobility and fragile skin. R9's plan of care documented staff were to encourage and assist in turning and repositioning at least every two hours and as needed for comfort and to offload pressure. R9's "Braden Scale for Prediction Pressure Sore Risk" dated 04/15/25 documented a score of 13 indicating a moderate risk for pressure ulcers. R9's "Weekly Wound Assessment" dated 06/04/25 documented R9 had a left lateral malleolus wound. R9's physician's orders under the "Orders" tab revealed the following orders: Apply barrier cream to buttock one time a day for wound healing and as needed (PRN), dated 05/07/25. Cleanse right lower leg distal/lateral ankle with cleanser and apply Skin-prep (liquid skin	F 686			

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F 686	Continued From page 33 protectant) to peri-wound. Apply Medi honey (wound dressing), then calcium alginate (highly absorbent dressing), and cover with a foam dressing one time a day for skin integrity, and as needed (PRN), dated 05/28/25. On 06/09/25 at 07:24 AM, R9 laid on his back on his bed. R9's heels were directly on his low air loss mattress. R9 had heel protector boots, one on the right-side bottom of his bed and one on the left-side bottom of his bed. On 06/10/25 at 07:50 AM, R9 laid on his back on his bed. R9's heels laid directly on his low air-loss mattress. One of R9's heel protector boots laid on his bedside table. On 06/11/25 at 7:26 AM, R9 laid on his back on his bed. R9's heels laid directly on the mattress. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated she did remind CNAs to ensure residents with wounds, or the residents that need their heels elevated have their heels elevated. LN G stated it was the nurse's responsibility to ensure boots were placed on the residents. LN G stated R9 needed to have his heels floated when in bed. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated if a resident needed boots on, or their heels floated, the nurse would let the CNAs know. CNA M stated the nurse also ensured heels were floating. On 06/11/25 at 12:05 PM, Administrative Nurse D stated the CNAs and nursing knew what residents needed to have their heels floated. Administrative Nurse D stated it was the responsibility of all nursing staff to ensure heels	F 686			

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F 686	Continued From page 34 were floated or boots were on the resident when the resident was in bed. The facility's "Prevention of Pressure Injuries" policy dated 10/24 documented the facility would identify specific risk factors and establish goals and prevention interventions with the physician's input. The facility would establish approaches to identify, stabilize, or minimize risk factors associated with pressure injuries.	F 686			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 12 residents, with three reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure pressurized supplemental oxygen tanks in a safe, locked area, and out of reach of the 22 cognitively impaired independently mobile residents. The facility additionally failed to ensure fall interventions were in place for Resident (R) 12 and R4. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings included:	F 689			

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F 689	Continued From page 35 - On 06/11/25 at 07:58 AM, a walkthrough of the facility revealed an unsecured oxygen storage room. The room contained 35 pressurized supplemental oxygen cylinder tanks stored in floor racks. The room had a key lock on the entry door. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated oxygen should be stored in a locked room in a storage rack. On 06/11/25 at 11:52 AM, Certified Nurse Aide (CNA) M stated oxygen tanks should be stored in a locked room in storage racks. On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected oxygen tanks would be stored in a locked room. The facility's "Fire Safety Precaution Including Oxygen Storage" policy last revised 04/2025 documented personnel would follow the facility's established fire safety precautions in order to provide safety to all concerned. - R12's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The "Significant Change Minimum Data Set (MDS)" dated 01/17/25 documented a Brief Interview of Mental Status (BIMS) score of six,	F 689			

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F 689	Continued From page 36 which indicated severely impaired cognition. The MDS documented R12 was dependent on staff assistance for transfers, dressing, and personal hygiene. The MDS documented R12 was on hospice services. The "Quarterly MDS" dated 04/29/25 documented a BIMS score of zero, which indicated severely impaired cognition. The MDS documented that R12 was dependent on staff assistance for bed mobility, dressing, personal hygiene, and transfers. The MDS documented R12 was on hospice services. R12's "Falls Care Area Assessment (CAA)" dated 02/07/25 documented she was dependent on a wheelchair for mobility related to her physical status of a fractured left hip and was on hospice services. R12's "Care Plan," initiated date of 09/24/18 and a revision date of 01/19/23, documented staff would keep the call light within reach. The plan of care documented staff would provide R12 with frequent education about how to use the call light and keep the call light secured and within reach. The plan of care dated 12/19/24 documented R12 had an injury fall on 12/18/24 and the intervention that was implemented was staff would remove the Hoyer (total body mechanical lift) sling after each use from under R12. The plan of care with an initiated date 04/22/25 documented R12 had an injury fall. The intervention that was implemented was staff would recline her in the Broda chair (specialized wheelchair with the ability to tilt and recline) after she was finished eating. The plan of care also documented Dycem (a non-slip mat used for stabilization and gripping to prevent slipping)	F 689			

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F 689	Continued From page 37 would be placed in her chair. The plan of care dated 06/05/25 documented R12 had an injury fall and the intervention implemented was the staff would ensure her bed was in the lowest position and a floor mat was in place next to the bed. On 06/09/25 at 08:15 AM, R12 laid on her back in bed. R12 call light was on the floor behind her bed. R12's floor mat was folded up and stood upright away from her bed. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated all staff have access to each resident's care plan. LN G stated it was all nursing staff's responsibility to ensure fall interventions were in place before leaving a resident's room. LN G stated staff could review the resident's fall interventions from the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated she did have access to the resident's care plans. CNA M stated if a new intervention for a fall was put in place the director of nursing would come to the floor and let all staff know. CNA M stated it was the CNA's job to ensure the interventions for falls were put in place before leaving the resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all nursing staff have access to the care plans. Administrative Nurse D stated she would expect the person who laid the resident down to ensure all fall interventions were put in place before leaving the resident's room. The facility's "Falls and Fall Risk Managing" policy	F 689			

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F 689	Continued From page 38 dated 04/24 documented based on previous evaluations and current data, the staff would identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. - R4's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (high blood pressure), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), hyperlipidemia (condition of elevated blood lipid levels), dementia (a progressive mental disorder characterized by failing memory and confusion), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), pain, insomnia (inability to sleep), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time). The "Quarterly Minimum Data Set" (MDS) for R4 dated 03/24/25 recorded a Brief Interview for Mental Status (BIMS) score of five, which	F 689			

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F 689	Continued From page 39 indicated severely impaired cognition. The MDS documented R4 needed setup or cleanup for eating and substantial to maximal assistance from staff for toileting and bathing. The MDS documented R4 had falls since admission. The MDS documented R4 had two non-injury falls. R4's "Falls Care Area Assessment "(CAA) dated 12/22/24 documented R4's fall CAA triggered related to R4 taking an antidepressant (a class of medications used to treat mood disorders) routinely. R4's "Care Plan" dated 03/14/23 documented R4 had a non-injury fall and staff would place her call light within her reach. R4's plan of care dated 09/05/24 documented a non-injury fall and the facility would place nonskid strips in front of her toilet. R4's plan of care dated 05/05/25 documented R4 was at risk for falls and has had an actual fall related to sliding out of her bed, R4's bed would be placed in a low position, a fall mat would be placed beside her bed, and her wheelchair would be placed at the bedside. On 06/09/25 at 07:34 AM, R4 laid on her bed, R4's bed was in a low position. R4's call light laid on the floor, and her fall mat was folded up at the top of her bed. R4 did not have nonskid strips in her bathroom. On 06/10/25 at 02:07 PM, R4 laid in on her bed. R4's bed was at waist height. R4's fall mat was folded up at the head of her bed. R4 did not have nonskid strips on her bathroom floor. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated all staff have access to each resident's care plan. LN G stated it was all nursing staff's			F 689			

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F 689	Continued From page 40 responsibility to ensure fall interventions were in place before leaving a resident's room. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated she did have access to the resident's care plans. CNA M stated if a new intervention for a fall was put in place the director of nursing would come to the floor and let all staff know. CNA M stated it was the CNA's job to ensure the interventions for falls were put in place before leaving the resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all nursing staff have access to the care plans. Administrative Nurse D stated she would expect the person who laid the resident down to ensure all fall interventions were put in place before leaving the resident's room. The facility's "Falls and Fall Risk Managing" policy dated 04/24 documented based on previous evaluations and current data, the staff would identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695			

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F 695	Continued From page 41 This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 33's continuous positive airway pressure (CPAP - ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored in a sanitary manner. This placed R33 at an increased risk for respiratory infection and complications. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of the acquired absence of right foot, pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral region, hematogenous osteomyelitis (a type of bone infection where bacteria travel through the bloodstream to the bones, causing inflammation and potentially bone destruction), lack of coordination, muscle weakness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Admission Minimum Data Set" (MDS) dated 04/21/25 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R33 had impairment on one side of her lower extremities. The MDS documented R33 needed setup or cleanup for eating, was dependent on staff for toileting, and needed	F 695			

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F 695	Continued From page 42 substantial to maximal assistance from staff for bathing. The MDS did not indicate R33 required the use of a CPAP. R33's "Functional Abilities (self-care mobility) Care Area Assessment" (CAA) dated 04/21/25 documented R33 was currently taking insulin (a hormone that lowers the level of glucose in the blood), antihypertensive (a class of medication used to treat high blood pressure), anticoagulation (blood thinner), and medication for constipation which could cause an increase in falls. The CAA documented R33 had had no falls since admission. The CAA documented R33 was dependent on staff for most activities of daily living (ADL) and required the assistance of one staff. The CAA documented R33 ambulated with a wheelchair and was dependent on staff for wheeling her chair. The CAA documented R33 received medication for wound healing. The CAA documented R33 was on a regular diet, with regular texture with thin liquids. The CAA documented R33 was incontinent and required a pull-up. R33's "Care Plan" dated 04/18/25 documented R33 was at risk for altered nutritional and hydration status related to inadequate intake and wound healing. R33's plan of care documented staff would encourage the consumption of fluids that were provided and monitor and record meal intakes. The plan of care for R33 documented staff would provide and serve supplements as ordered. R33's plan of care lacked indication of R33's CPAP. R33's EMR under the "Orders" tab lacked staff direction for the use, and cleaning of CPAP and lacked staff direction for sanitary storage of	F 695			

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F 695	Continued From page 43 CPAP. R33's EMR under "Progress Notes" dated 05/29/25 documented Licensed Nurse (LN) received a call from the X-ray department for a follow-up on R33's chest X-ray findings. The findings indicated left basal infiltrate/effusion (abnormal accumulation of fluid or other substances in the lower part(basal)of the lungs, specifically within the lung tissue (infiltrate) or in the space around the lungs(effusion). LN called the physician on call and received an order for the facility to continue Levaquin (antibiotic) as ordered. On 06/09/25 at 07:57 AM, R33 laid on her right side in her bed. R33's CPAP mask was draped over the CPAP machine without a clean barrier and sanitary container. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated CPAP mask should be cleaned, air-dried, and placed in a plastic bag. LN G stated R33 used a CPAP. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated the CPAP mask should be placed in a drawer. She stated the nurse on duty usually took care of the respiratory equipment. On 06/11/25 at 02:05 PM, Administrative Nurse D stated it was all nursing staff's duty to ensure all respiratory equipment was placed in a bag in a sanitary manner. The facility did not provide a respiratory storage policy.	F 695			
F 732 SS=C	Posted Nurse Staffing Information	F 732			

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F 732	Continued From page 44 CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			F 732			

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F 732	Continued From page 45 This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to post its updated daily posted staffing sheet. Findings included: - On 06/09/25 at 07:04 AM an inspection of the facility revealed the facility's "Direct Care Report" form posted on the wall across from the nurse's station. The form was dated 06/06/25. On 06/09/25 at 07:04 AM, Licensed Nurse (LN) I stated nursing staff were responsible for updating the form each day and posting it. On 06/11/25 at 12:24 PM, Administrative Nurse D stated the charge nurse was responsible for creating and posting the staffing form each day. A review of the facility's "Staffing" policy revised 11/2023 indicated that staffing hours must be maintained for facility records for a minimum of 18 months. The policy indicated the records must be made available upon request.	F 732			
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 744			

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F 744	Continued From page 46 The facility identified a census of 36 residents. The sample included 12 residents, with two residents reviewed for dementia (a progressive mental disorder characterized by failing memory and confusion) care. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 17 with dementia services related to supervision and accidents. The defiant practice placed R17 at risk for preventable accidents. Findings Included: - R17's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of a history of falls, muscle weakness, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), insomnia (inability to sleep), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), unsteadiness on feet, and peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The "Annual Minimum Data Set" (MDS) dated 03/23/25 documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R17 needed set-up or clean-up assistance with eating, and substantial/maximal assistance from staff for toileting and bathing. The MDS documented R17 had a fall since admission and had two or more non-injury falls.	F 744			

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F 744	Continued From page 47 R17's " Communication Care Area Assessment" (CAA) dated 03/23/25 documented R17's CAA related to R17 not understanding others, and others not understanding her. The CAA documented R17 was alert to herself only. R17's "Care Plan" dated 07/02/19 documented staff were to keep R17's call light within her reach. R17's plan of care dated 05/29/23 documented a non-injury fall related to R17 walking unassisted and without calling for assistance, the intervention for the fall was to keep R17's door open, for staff to easily view R17. A "Facility Incident Report #5635" completed on 05/27/25 revealed Licensed Nurse (LN) H walked into the television room and witnessed R17 (Severely cognitively impaired resident) in the television room with R21. LN H witnessed R21 groping R17's breast. The report indicated both residents were immediately separated. The note revealed that R17 was assessed with no injuries found. The report indicated both residents had no recollection of the incident when interviewed. The note revealed the medical provider, resident representative, and local law enforcement were notified. The report revealed that R21 was immediately placed on one-to-one supervision and started on medication to reduce his sexual behaviors. A "Witness Statement" completed by LN H on 05/27/25 indicated he observed the incident and separated the two residents. LN H reported in the statement he observed R21 touching R17's breast with his left hand. LN H reported in the statement that he immediately separated the residents and assessed R17. The statement	F 744			

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F 744	Continued From page 48 revealed that R21 was agitated when asked to not touch R17. On 06/09/25 at 07:28 AM, R17's laid on her bed, and R17's call light laid on the floor. R17's call light was not within her reach. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated residents with dementia should be left alone and should be monitored frequently. LN G stated call lights should always be within the resident's reach. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated residents with dementia should be checked on frequently. CNA M stated resident's call light should be laid on the resident, always within the resident's reach. On 06/11/25 at 12:05 PM, Administrative Nurse D stated that residents with dementia should be monitored. Administrative Nurse D stated call lights should be within the resident's reach. The facility's "Dementia Care of the Resident" policy dated 10/24 documented that residents with diagnosed dementia or displays symptoms of dementia would receive necessary care and services to maintain or attain their highest practicable physical, mental, and psychosocial well-being.	F 744			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756			

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F 756	Continued From page 49 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and	F 756			

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F 756	Continued From page 50 interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities in Resident (R) 1's medication which lacked an indication for administration. The facility also failed to ensure the CP identified and reported the physician's order for monitoring the pulse for an antihypertensive (a class of medication used to treat high blood pressure) medication. This deficient practice placed R1 at risk for unnecessary medication use, side effects, and physical complications. Findings included: - R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (HTN - elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), calculus (a hardened deposit, usually composed of mineral salts, that forms within the body) of the gallbladder, and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The "Annual Minimum Data Set (MDS)" dated 09/19/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had received anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, diuretic (a medication to promote the formation and			F 756			

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F 756	Continued From page 51 excretion of urine) medication, opioid (a class of controlled drugs used to treat pain) medication, and hypoglycemic (a class of medication used to lower blood sugar) medication during the observation period. The "Quarterly MDS" dated 02/20/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R1 had received anticoagulant medication, antidepressant medication, antianxiety medication, antiplatelet medication, diuretic medication, opioid medication, and hypoglycemic medication during the observation period. R1's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)" dated 10/07/24 documented she received anticoagulant therapy and psychotropic medications with monitoring in place. R1's "Care Plan," dated 10/28/22, documented staff were educated on the administration of giving medication as ordered and the five rights of medication administration. R1's EMR under the "Orders" tab revealed the following physician orders: Ursodiol, (medication used to dissolve gallstones) oral capsule 300 milligrams (mg) give one capsule by mouth three times a day, dated 04/8/25. The medication order lacked an indication for administration. Tamsulosin (medication used to assist with the output of urine) capsule 0.4 mg, give one capsule by mouth daily, dated 04/8/25. The medication order lacked an indication for administration. Cymbalta (antidepressant) oral capsule, delayed release particles, 20 mg give one capsule by	F 756			

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F 756	Continued From page 52 mouth daily, dated 04/22/25. The medication order lacked an indication for administration. Metoprolol succinate (antihypertensive) tablet extended release 24-hour 25 mg give one tablet by mouth daily for HTN, hold for systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) less than (<) 110 millimeters (mm) of mercury (Hg) and a heart rate < 60 beats per minute. Do not crush medication, dated 04/09/25. Review of R1's "Medication Administration Record (MAR)," "Treatment Administration Record (TAR)", and her EMR from 03/01/25 to 06/09/25 (100 days) lacked heart monitoring as ordered by the physician for antihypertensive medication Metoprolol revealed for 61 days. The MMR's lacked evidence of the CP identified the lack of indication for medication administration. Review of the "Monthly Medication Review" (MMR) from June 2024 to May 2025 documented recommendations from March 2023 to review antihypertensive medication orders for hold parameters and physician notification. The MMR's lacked CP noted the irregularities of no indication for medication administration and heart monitoring for antihypertensive medication. On 06/10/25 at 08:26 AM, R1 propelled herself in her wheelchair from her room to the dining room without difficulty. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated every medication required an indication for administration. LN G stated she would clarify an order if there was no indication for administration. LN G stated if the physician had a specific parameter for monitoring a resident's heart rate,	F 756			

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F 756	Continued From page 53 then the heart rate should be obtained prior to medication administration. On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected a physician's order to be followed. Administrative Nurse D stated if the physician had ordered a heart rate to monitor for hypertensive medication, she expected the heart rate to be obtained prior to medication administration. Administrative Nurse D stated every medication required and indication for administration. The facility's Medication Regimen Reviews" policy last reviewed 02/2025 documented the Consultant Pharmacist would review the medication regimen per state and federal guidelines. The policy directed reporting of "irregularities" to the attending physician, the facility medical director, and the director of nursing.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757			

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F 757	Continued From page 54 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure physician parameters were followed for a hypertensive medication (class of medication used to treat hypertension (high blood pressure) for Resident (R) 1. The facility also failed to ensure R1's medication had an indication for administration. These deficient practices placed R1 at risk for the potential of unnecessary medication administration thus leading to possible harmful side effects. Findings included: - R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (HTN - elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), calculus (a hardened deposit, usually composed of mineral salts, that forms within the body) of the gallbladder, and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The "Annual Minimum Data Set (MDS)" dated	F 757			

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F 757	Continued From page 55 09/19/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had received anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, diuretic (a medication to promote the formation and excretion of urine) medication, opioid (a class of controlled drugs used to treat pain) medication, and hypoglycemic (a class of medication used to lower blood sugar) medication during the observation period. The "Quarterly MDS" dated 02/20/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R1 had received anticoagulant medication, antidepressant medication, antianxiety medication, antiplatelet medication, diuretic medication, opioid medication, and hypoglycemic medication during the observation period. R1's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)" dated 10/07/24 documented she received anticoagulant therapy and psychotropic medications with monitoring in place. R1's "Care Plan," dated 10/28/22, documented staff were educated on the administration of giving medication as ordered and the five rights of medication administration. R1's EMR under the "Orders" tab revealed the	F 757			

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F 757	Continued From page 56 following physician orders: Ursodiol (medication used to dissolve gallstones) oral capsule 300 milligrams (mg) give one capsule by mouth three times a day, dated 04/8/25. The medication order lacked an indication for administration. Tamsulosin (medication used to assist with the output of urine) capsule 0.4 mg, give one capsule by mouth daily, dated 04/8/25. The medication order lacked an indication for administration. Metoprolol succinate (antihypertensive) tablet extended release 24-hour 25 mg give one tablet by mouth daily for HTN, hold for systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) less than (<) 110 millimeters (mm) of mercury (Hg) and a heart rate < 60 beats per minute. Do not crush medication, dated 04/09/25. Review of R1's "Medication Administration Record (MAR)," "Treatment Administration Record (TAR)," and her EMR from 03/01/25 to 06/09/25 (100 days) lacked heart monitoring as ordered by the physician for antihypertensive medication Metoprolol revealed for 61 days. The MMR's lacked evidence of the CP identified the lack of indication for medication administration. Review of the "Monthly Medication Review" (MMR) from June 2024 to May 2025 documented recommendations from March 2023 to review antihypertensive medication orders for hold parameters and physician notification. The MMR's lacked CP noted the irregularities of no indication for medication administration and heart monitoring for antihypertensive medication. On 06/10/25 at 08:26 AM, R1 propelled herself in her wheelchair from her room to the dining room	F 757			

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F 757	Continued From page 57 without difficulty. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated every medication required an indication for administration. LN G stated she would clarify an order if there was no indication for administration. LN G stated if the physician had a specific parameter for monitoring a resident's heart rate, then the heart rate should be obtained prior to medication administration. On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected a physician's order to be followed. Administrative Nurse D stated if the physician had ordered a heart rate to monitor for hypertensive medication, she expected the heart rate to be obtained prior to medication administration. Administrative Nurse D stated every medication required and indication for administration. The facility's "Unnecessary Medications" policy last reviewed 04/2025 documented the resident's drug regimen would be free from unnecessary drugs. Residents or their representatives had the right to refuse ordered medications. Unnecessary Drug - was any drug used in excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued or any combination of the reasons above. Adequate Indications for Use - refers to the identified, documented clinical rationale for administering a medication that was based upon an assessment of the resident's condition and therapeutic goals, and after any safer treatments have been deemed clinically contraindicated.	F 757			

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F 757	Continued From page 58 Also, adequate indication for use means that the medication administered was consistent with the manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.	F 757			
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or	F 801			

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F 801	Continued From page 59 nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations	F 801			

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F 801	Continued From page 60 including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The facility failed to provide the services of a full-time certified dietary manager for the 36 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 09/09/25 at 08:23 AM, Dietary Staff BB stated she was currently in class to become a Certified Dietary Manager (CDM). Dietary Staff BB stated the Registered Dietician (RD) came to the facility monthly. The facility's "Food Service Staffing" policy last reviewed 10/2024 documented the facility would employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service.	F 801			
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what	F 838			

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NAME OF PROVIDER OR SUPPLIER SPRING HILL CARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 251 E WILSON AVENUE SPRING HILL, KS 66083		
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F 838	Continued From page 61 resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including	F 838			

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F 838	Continued From page 62 but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a) (1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.	F 838			

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F 838	Continued From page 63 (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents. Based on observations, interviews, and record reviews, the	F 838			

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F 838	Continued From page 64 facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 36 residents residing in the facility. Findings Included: - On 06/09/25 Administrative Staff A provided a "Facility Assessment" updated 12/2024. A review of the assessment revealed the following: The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift, day, and weekend. On 06/09/25 a review of the facility's Payroll Based Journaling (PBJ - Staffing Data Report) from 04/01/24 to 03/31/25 revealed excessively low weekend staffing triggered on Quarter Three (04/01/24 to 06/30/24) and Quarter Four (07/01/24 to 09/30/24). On 06/11/24 at 12:24 PM, Administrative Nurse D stated the facility assessment update was completed recently by the management team. She stated the assessment should include the staffing requirements. On 06/11/24 at 01:22 PM, Administrator A stated the assessment was recently updated to include the staffing requirement put out by the Centers for Medicare and Medicaid Services (CMS).	F 838			

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F 838	Continued From page 65	F 838			
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out	F 849			

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F 849	Continued From page 66 at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical	F 849			

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F 849	Continued From page 67 supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the	F 849			

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F 849	Continued From page 68 resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff	F 849			

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F 849	Continued From page 69 furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included 12 residents, with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to provide a description of the medication and equipment provided to Resident (R) 12 by hospice. This deficient practice created a risk for missed or delayed services, impaired physical, and psychosocial care for R12. Findings included: - R12's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The "Significant Change Minimum Data Set (MDS)" dated 01/17/25 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The	F 849			

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F 849	Continued From page 70 MDS documented R12 was dependent on staff assistance for transfers, dressing, and personal hygiene. The MDS documented R12 was on hospice services. The "Quarterly MDS" dated 04/29/25 documented a BIMS score of zero, which indicated severely impaired cognition. The MDS documented that R12 was dependent on staff assistance for bed mobility, dressing, personal hygiene, and transfers. The MDS documented R12 was on hospice services. R12's "Cognitive Loss/Dementia Care Area Assessment (CAA)", dated 02/07/25 documented she was dependent on a wheelchair for mobility related to her physical status of a fractured left hip and was on hospice services. R12's "Care Plan," dated 01/14/25 documented the nursing staff would notify the hospice provider of any changes in R12's condition. The plan of care documented hospice would provide nursing visits two times weekly and as needed, a bath aide would visit two times weekly, social services would visit monthly and as needed, and the chaplain would visit monthly and as needed. R12's EMR under the "Orders" tab revealed the following physician orders: Admit to hospice with a diagnosis of senile degeneration of the brain, dated 01/14/25. On 06/09/25 at 08:15 AM, R12 laid on her back in bed. R12 call light was on the floor behind her bed on the floor. R12's floor mat was folded up and stood upright away from her bed. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G	F 849			

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F 849	Continued From page 71 stated hospice provider supplied a notebook for each resident on hospice services. LN G stated she would refer to the notebook provided by hospice for any information concerning R12's hospice care. LN G stated the hospice information should also be on R12's person-centered care plan. LN G stated R12's care plan should include the equipment supplied and medication covered by the hospice provider. On 06/11/25 at 11:52 AM, Certified Nurse Aide (CNA) M stated she would know which residents were on hospice services if there was a hospice notebook in the cupboard at the nurse's station. CNA M stated the items provided by the hospice provider should be included in the resident's care plan. On 06/11/25 at 12:05 PM, Administrative Nurse D stated everyone had access to the resident's care plans and their Kardex (a nursing tool that gives a brief overview of the care needs of each resident). Administrative Nurse D stated the hospice information should be the resident's care plan with the information of what services, supplies, and equipment that was provided by hospice. The facility's "Hospice Program" policy last reviewed 10/2024 documented the facility may contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. The facility may limit the hospice providers as related to the coordination and communication of care within the community.	F 849			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5)	F 851			

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F 851	Continued From page 72 §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including,	F 851			

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F 851	Continued From page 73 but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility reported a census of 36 residents. The sample included 12 residents. Based on record review and interviews, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ - Staffing Data Report), when the facility failed to submit accurate weekend staffing coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - A review of the facility's submitted PBJ data from 04/01/24 through 03/31/25 indicated the facility triggered for excessively low weekend staffing for Fiscal Year (FY) Quarter Three (04/01/24 to 06/30/24) and FY Quarter Four	F 851			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 851	Continued From page 74 (07/01/24 to 09/30/24). A review of the facility's working schedule, time sheets/punches, and posted staffing hours indicated no gaps or loss of hours. On 06/09/25, a review of the "Facility Assessment" updated 12/2024 revealed the assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aide (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift, day, and weekend. On 06/11/25 at 11:30 AM, Licensed Nurse (LN) G stated she worked weekends and didn't have concerns related to low weekend staffing. She stated the nurse manager would come in and help if the staff called off. On 06/11/25 at 12:24 PM, Administrative Nurse D stated the facility had gaps in staffing or issues with weekend staffing. She stated the facility provided incentives for staff to pick up extra shifts and other staff could cover any open shift. On 06/11/25 at 01:04 PM, Administrator A stated the facility recently switched to a new tracking system but the facility has been adequately staffed. He stated the facility has been triggered for low weekend staffing several times when the facility had no issues with staffing. The facility's "Payroll-Based Journaling" policy revised 11/2017 indicated staffing and census information will be reported electronically to the	F 851			

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F 851	Continued From page 75 Centers for Medicare and Medicaid Services (CMS). The policy indicated staffing information during the recorded time period shall be made available to residents, family members, and the public within 24 hours of a written or verbal request.	F 851			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880			

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F 880	Continued From page 76 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The facility identified eight residents on Enhanced Barrier Precautions (EBP - infection control	F 880			

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F 880	Continued From page 77 interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to store Resident (R) 33, R34, R6, and R1's respiratory equipment in a sanitary manner, and the facility further failed to transport linens in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Included findings: - On 06/09/25 at 07:44 AM, a walkthrough of the facility was completed. On 06/09/25 at 07:57 AM, R33 laid on her right side in her bed. R33's CPAP mask was draped over the CPAP machine without a clean barrier and sanitary container. On 06/09/25 at 07:59 AM, R34 laid on his back on his bed. R34's CPAP mask laid on the floor on the right side of his bed. R34's CPAP machine without a clean barrier and sanitary container. On 06/09/25 at 08:02 AM, R6's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask hung from a thumb tack on her message board. R6's nebulizer mask was not stored in a sanitary manner. On 06/09/25 at 08:04 AM, R1's nasal cannula laid draped over her wheelchair. R1's nasal cannula was not contained in a sanitary manner. On 06/09/25 at 08:10 AM, laundry staff pushed a covered linen cart down the West Hall with bath blankets on top of the cart. The bath blankets	F 880			

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F 880	Continued From page 78 were not stored in a sanitary manner. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated CPAP mask should be cleaned, air-dried, and placed in a plastic bag. LN G stated R33 used a CPAP. LN G stated linens should be transported in a cover cart. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated the CPAP mask should be placed in a drawer. She stated the nurse on duty usually took care of the respiratory equipment. CNA M stated she was unsure how linens should be transported. On 06/11/25 at 2:05 PM, Administrative Nurse D stated it was all nursing staff's duty to ensure all respiratory equipment was placed in a bag in a sanitary manner. Administrative Nurse D stated linens should be covered when transported in the halls. The facility did not provide a respiratory equipment storage policy. The facility's "Handling of Clean Linen and Linen Distribution" policy dated 10/24 documented clean laundry and bedding shall be handled in a manner that prevents gross microbial contamination of the air and person handling the linen.	F 880			