STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST , LINCOLN, Kansas, 67455

(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
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey. The 2567 was sent electronically on 09/04/25.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 34 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R)1 had a physician's order and was assessed for the ability to safely self-administer medications left at the bedside. This placed R1 at risk for improper use of medications and related side effects. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), edema (swelling resulting from an excessive accumulation of fluid in the body tissue), chronic pain, anxiety (mental or emotional reaction characterized by apprehension uncertainty, and irrational fear), hypertension (high blood pressure), and atrial fibrillation (rapid, irregular heartbeat). The "Admission Minimum Data Set" (MDS), dated 07/28/25, documented R1 had moderately impaired cognition. R1 required supervision with bathing, and was independent with dressing, toileting, hygiene, eating, mobility, transfers, and oral care. The MDS further documented R1 received anticoagulant (a class of medication used to	F0554		

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 reverse for further 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.

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

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F0554 SS = D	Continued from page 1 prevent the blood from clotting), diuretic (a medication to promote the formation and excretion of urine), and opioid (a class of controlled drug used to treat pain) medication. R1's "Care Plan" dated 07/22/25 directed staff to administer medications as ordered and monitor for side effects, administer supplemental oxygen as ordered to keep oxygen saturation (percentage of oxygen in the blood) above 90%. The "Self-Administration of Medications Assessment," dated 07/28/25, documented R1 required assistance for all medications, including inhalants. R1's EMR lacked a physician's order that allowed R1 to keep medications at her bedside and self-administer. The "Physician's Order," dated 07/22/25, directed staff to administer Breztri Aerosphere (an inhaler used for the maintenance treatment of COPD), 160-9-4.8 mcg (micrograms), two puffs, twice a day for COPD. On 08/19/25 at 09:00 AM, observation revealed Licensed Nurse (LN) H went into R1's room to administer her Breztri inhaler. When she opened the box, the inhaler was not in it. R1 stated, "The inhaler is over here," and pointed to the table next to her recliner. LN H stated, "I will have to get an order for the inhaler to be left in your room; it cannot be left in your room without it." R1 took the inhaler and self-administered 2 puffs into her mouth. On 08/20/25 at 12:20 PM, Administrative Nurse D stated that there should be an order before any medication can be left at a resident's bedside, and there also needs an assessment to make sure the resident can self-administer medication. The facility's "Self-Administration of Medications" policy, dated 02/21, documented that the residents have the right to self-administer medications if the interdisciplinary team (IDT) had determined that it was clinically appropriate and safe for the resident to do so. The policy further documented, as part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.	F0554		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F0583		

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F0583 SS = D	Continued from page 2 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 34 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure staff secured and protected the privacy and confidentiality of Resident (R) 24's medical record. This placed this resident at risk for impaired right to confidentiality. Findings included: - On 08/19/25 at 08:08 AM, an observation revealed that facility staff left R24's point of care (POC) information of the Electronic Medical Record (EMR) open and visible on the east medication cart laptop.	F0583		

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F0583 SS = D	Continued from page 3 On 08/19/25 at 08:09 AM, Certified Medication Aide (CMA) R stated the screen should not be left unlocked with resident information open. On 08/20/25 at 09:02 AM, Licensed Nurse (LN) G stated that the medication cart and the laptop screen should always be locked when away from the cart. On 08/20/25 at 12:15 PM, Administrative Nurse D stated she would expect any nursing staff to lock any screen on the laptop, and the medication cart should always be locked as well when a staff member was not in direct sight of the cart. The facility's undated "Protected Health Information (PHI), Management and Protection of" policy documented that PHI shall not be used or disclosed except as permitted by current federal and state laws.	F0583		
F0605 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 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	F0605		

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F0605 SS = D	Continued from page 4 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 (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	F0605		

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F0605 SS = D	Continued from page 5 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. §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 had a census of 34 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to obtain a stop date for Resident (R) 10's as needed (PRN) Ativan (an antianxiety medication class of medication that calms and relaxes people). The facility failed to ensure an appropriate indication for R17's Seroquel (an antipsychotic) and failed to document a physician's rationale and the risks versus benefits for the Seroquel use. The facility further failed to obtain a gradual dose reduction (GDR) for R6. This placed the residents at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. Findings included: - The Electronic Medical Record for R10 documented diagnoses of vascular dementia (a progressive mental	F0605		

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F0605 SS = D	Continued from page 6 disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The" Significant Change Minimum Data Set" (MDS), dated 11/22/24, documented R10 had intact cognition. R10 required supervision with bathing and was independent with all other activities of daily living. The MDS further documented R10 received antipsychotic (a class of medications used to treat major mental conditions), antidepressant (a class of medications used to treat mood disorders), and antianxiety (a class of medications used to calm and relax people). The "Quarterly MDS," dated 05/23/25, documented R10 had intact cognition. R10 required supervision with showers and dressing and was independent with all other activities of daily living. R10 received antipsychotic, antidepressant, and antianxiety medications daily. R10's "Care Plan" dated 08/04/25, initiated on 07/14/25, documented R10 was at risk for complications from medications with Black Box Warning (BBW- highest safety-related Warning that medications can have assigned by the Food and Drug Administration), and directed staff to administer medications as ordered by the physician, monitor for side effects, and the pharmacist would review her medications monthly. The" Physician's Order," dated 02/23/25, directed staff to administer Ativan (an antianxiety medication), 1 milligram (mg), by mouth every four hours, PRN, for restlessness and anxiety. The order lacked a stop date for the PRN medication. On 08/19/25 at 08:00 AM, Licensed Nurse (LN) H administered R10's medications without issue or concern. On 08/20/25 at 12:15 PM, Administrative Nurse D stated R10's Ativan should have a stop date and be reassessed by the physician. Upon request, a policy for Psychotropic Medication Use was not provided by the facility. - The Electronic Medical Record for R17 documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory	F0605		

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F0605 SS = D	Continued from page 7 failure), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The “Annual Minimum Data Set” (MDS), dated 12/27/24, documented R17 had severely impaired cognition. R17 required substantial staff assistance for toileting, hygiene, and personal hygiene. R17 was independent with eating, dressing, mobility, transfers, and ambulation. The MDS further documented R17 received antidepressant (a class of medications used to treat mood disorders) and antianxiety (a class of medications used to calm and relax people) medication daily. The “Quarterly Minimum Data Set (MDS),” dated 06/20/25, documented R17 had severely impaired cognition. R17 required supervision from staff for personal hygiene, eating, oral care, dressing, and set up assistance with mobility and transfers. The MDS further documented R17 received antipsychotic (a class of medications used to treat major mental conditions), antidepressant, and antianxiety medication daily. R17’s “Care Plan” dated 07/02/25, initiated on 02/12/24, directed staff to converse with R17 while providing care, encourage activities, encourage family involvement, and facilitate resident interaction. The update, dated 01/15/24, documented R17 was at risk for adverse reactions from medications with Black Box Warning (BBW- the highest safety-related Warning that medications can have assigned by the Food and Drug Administration) and directed staff to monitor for signs and symptoms of side effects from the medications. The care plan update, dated 01/16/24, directed staff to cue, reorient, and supervise as needed and use task segmentation to support short-term memory deficits. The care plan update, dated 04/07/25, directed staff to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate, at least quarterly. The “Physician’s Order,” dated 01/27/25, directed staff to administer Seroquel (an antipsychotic medication), 12.5 milligrams (mg), by mouth, at bedtime, for anxiety and agitation. The medication was increased to twice per day on 03/07/25. On 08/19/25 at 08:30 AM, Certified Medication Aide (CMA) R administered R17’s medication with a lot of encouragement and discussion. CMA R stated R17 had periods of crying and, at times, aggression. CMA R further stated that staff provided 1:1 care, took her	F0605		

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F0605 SS = D	Continued from page 8 to activities, and she had as-needed anxiety medication. On 08/20/25 at 10:20 AM, Licensed Nurse (LN) H stated R17 had a lot of anxiety and at times she seems to be afraid to be alone. LN H further stated that staff provided a lot of 1:1 activities with her to help with the anxiety. On 08/20/25 at 12:15 PM, Administrative Nurse D stated the physician needed to provide an ongoing indication or risk versus benefit for her Seroquel. Administrative Nurse D verified that agitation was not an appropriate diagnosis for the Seroquel use. Upon request, a policy for Antipsychotic Medication Use was not provided by the facility. - R6‘s “Electronic Medical Record” included diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and major depressive disorder (major mood disorder which causes persistent feelings of sadness). R6‘s “Quarterly Minimum Data Set” (MDS), dated 05/15/25, documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment, and no mood issues or behaviors. The MDS documented R6 required substantial staff assistance with most activities of daily living. The MDS documented R6 received insulin (a hormone that lowers the level of glucose in the blood), antidepressant (a class of medications used to treat mood disorders), and anticonvulsant (a drug that is used to prevent or treat seizures or convulsions by controlling abnormal electrical activity in the brain) medications. R6‘s "Care Plan," dated 05/15/25, directed staff to administer medications as ordered. R6's plan of care directed staff to monitor for side effects and effectiveness, initiated 07/12/19. The “Physician Order,” dated 07/12/19, directed staff to administer Sertraline, 50 milligrams (mg) by mouth daily, related to major depressive disorder, a single episode. The Consultant Pharmacist's review on 05/05/25 recommended a gradual dose reduction (GDR) of sertraline or a rationale explaining the decision for continuing the sertraline. No physician response was documented.	F0605		

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F0605 SS = D	Continued from page 9 On 08/19/25, upon request, the consultant pharmacist sent to the facility the February 2025 “Drug Regimen Review,” which recommended a GDR, rationale, or risk versus benefit statement for sertraline. On 08/19/25 at 09:15 AM, Licensed Nurse (LN) H administered medications to R6. He took them whole in pudding with water. On 08/19/25 at 03:55 PM, Administrative Nurse D stated the pharmacist consultant had forgotten to send the February 2025 drug regimen reviews to the facility. She verified R6’s physician would not have received the February 2025 recommendation. Administrative Nurse D verified the physician had not responded to the 05/05/25 recommendation. Upon request, the facility did not provide a policy for Psychotropic drugs. The facility’s “Pharmacy Services” policy, dated April 2019, stated the consultant pharmacist will provide specific activities related to medication regimen review, including: A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated. Providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review.	F0605		
F0657 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	F0657		

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F0657 SS = D	Continued from page 10 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). 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 34 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 38's care plan was revised with interventions to reflect his current level of staff assistance her required after a recent hospital stay and on hospice care. The facility failed to update R2's care plan with interventions related to the need for enhanced barrier precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care). This placed R38 and R2 at risk for delayed or missed care. Findings included: - The Electronic Medical Record (EMR) for R2 had diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).	F0657		

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F0657 SS = D	Continued from page 11 The “Quarterly Minimum Data Set” (MDS), dated 07/11/25, documented R2 had severely impaired cognition. R2 was dependent upon staff for all activities of daily living, had a Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters), and was on received Hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. R2’s “Care Plan,” dated 07/17/25, initiated on 07/12/23, documented R2 had actual skin impairment due to dry skin and limited mobility. The care plan directed staff to follow policies/protocols for the prevention and treatment of skin breakdown, monitor, and report any changes in skin status. The care plan lacked documentation. R2 was on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) and lacked direction to staff on what personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) to use. The” Physician’s Order,” dated 07/22/25, directed staff to apply Opti foam (a brand of foam wound dressing designed to absorb fluid and protect wounds) to her Stage 2 pressure ulcer, change the dressing every seven days and as needed, and discontinue when healed. On 08/20/25 at 10:15 AM, Licensed Nurse (LN) G and LN H sanitized their hands and donned clean gloves. LN G stated R2 had recently gotten a small open area on her coccyx. LN H got on the side of the bed closest to the wall, and LN G was on the opposite side. R2 had bilateral heel protectors on, and LN G pulled down her pants, checked her incontinence brief, and stated she had a bowel movement (bm). R2’s heel protectors and pants were removed due to LN G had gotten BM on her pants while she was providing personal care. Both LN G and LN H removed their soiled glove and donned clean gloves. LN G and LN H assisted R2 onto her left side so that LN H could perform wound care. LN H removed the old dressing, used gauze to cleanse the wound, placed the wound cleanser on the bed, and measured the wound. LN H put Opti foam on R2’s wound, assisted with a clean brief, and still had on soiled gloves. LN H verified that she should have changed her gloves after she cleansed the wound. LN H stated that she had discussed with Administrative Nurse D that R2 needed to be on EBP, and she had not done it yet. LN H stated, it was on her list and would do it right away.	F0657		

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F0657 SS = D	Continued from page 12 On 08/20/25 at 11:00 AM, Certified Nurse Aide (CNA) N stated she did not know that R2 required EBP and that she had never worn a gown while she provided care to R2, only gloves. On 08/20/25 at 12:20 PM, Administrative Nurse D stated R2 should be on EBP due to her open area and that staff should have changed her gloves after she cleaned R2's wound. Administrative Nurse D further stated she would review the care plan and make sure the EBP information was on the care plan. The facility's "Care Plans, Comprehensive Person-Centered" policy, dated 03/22, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the physical, psychosocial, and functional needs was developed for each resident. The interdisciplinary team reviewed and updated the care plan when there has been a significant change in the resident's condition, at least quarterly, and when a resident has been readmitted to the facility from a hospital stay. - The "Medical Diagnosis" tab of R38's Electronic Medical Record (EMR) documented diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), hypertension (HTN- elevated blood pressure), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as the result of pressure, or pressure in combination with shear and/or friction) of the sacral region (area between the posterior hip bones), and osteomyelitis (local or generalized infection of the bone and bone marrow). R38's "Significant Change Minimum Data Set (MDS)" dated 08/13/25 documented he had a Brief Interview for Mental Status (BIMS) score of seven, which indicated moderately impaired cognition. R38 required substantial to being dependent on staff for his activities of daily living (ADL) cares. R38 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and an ostomy (surgical opening from an area inside the body to the outside). R38 had a Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) pressure ulcer. R38 was on Hospice services. R38's "Functional Abilities Care Area Assessment (CAA)" dated 08/15/25 documented he was a 61-year-old male admitted on hospice with osteomyelitis of the sacral and sacrococcygeal (area located at the base of the spine) region. R38 presented with a pressure ulcer,	F0657		

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F0657 SS = D	Continued from page 13 Stage 4 of the sacral region (left buttocks), chronic paraplegia, and multiple comorbidities. R38 has severe cognitive impairment. R38's "Care Plan," last revised 08/15/25, directed staff for his activities of daily living (ADL) cares: for bathing, he had been getting showers one to two times per week. The Care Plan documented R38 used a shower chair and a sit-to-stand (device to assist with going from a seated position to standing) for transfers, and R38 shaved himself daily independently. The Care Plan directed staff that on occasion, R38 would get up in his wheelchair and he could independently propel himself. The Care Plan directed staff that, due to the R38's inability to safely ambulate, stair climbing, and walking would not be routinely assessed or documented by direct care staff. The Care Plan documented these activities posed a safety risk and are not within the resident's current functional capabilities. The Care Plan directed staff R38 liked to reposition himself and would request help if needed, dressing, and R38 could dress himself. The Care Plan documented R38 wore a shirt only and a brief, but R38 did not wear pants. The Care Plan documented R38 was able to eat independently with set-up help only, was on a regular diet, and preferred high protein. The Care Plan documented R38 was able to do his own oral care with set-up help only. The Care Plan documented R38 required the assistance of one staff member with personal hygiene. The Care Plan documented R38 had his own wipes and were kept in his room. R38 was incontinent of bowel and does not use the toilet. R38 would tell you when he needs to be changed. The Care Plan documented R38 used a bedpan for bowel movements; he has a metal bedpan and a plastic one. R38 required a mechanical lift full lift with two assist. R38 refused to get up in his wheelchair or recliner most time. R38 often moved and turned himself fast and often bangs his arms around on the side rails and headboard while doing so. R38 requests that staff move out of the way while moving himself. R38 had a hospital stay from 07/22/25 to 08/07/25. Upon R38's return from the hospital, he was placed on hospice services. R38's care plan was not revised and updated to reflect his current ADL care needs as indicated from his "Significant Change MDS" on 08/13/25. On 08/20/25 at 12:15 PM, Administrative Nurse D stated that R38's care plan should have been updated with his most current level of care needed after his return from the hospital. Administrative Nurse D stated she had gotten behind on the updates on the care plans, and she	F0657		

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F0657 SS = D	Continued from page 14 took responsibility for that. The facility's "Care Plans, Comprehensive Person-Centered" policy, dated March 2022, documented the comprehensive, person-centered care plan was developed within seven days of the completion of the required MDS assessment, and no more than 21 days after admission. The interdisciplinary team (IDT) reviewed and updated the care plan when there had been a significant change in the resident's condition; when the desired outcome was not met; when the resident had been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment.	F0657		
F0695 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. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 34 residents. The sample included 13 residents, with one reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to provide adequate respiratory care and services for Resident (R) 10 when staff failed to store their oxygen tubing and cannula (a medical device used to deliver supplemental oxygen through the nostril) and nebulizer (a medical device that converts liquid medication into a fine mist, allowing it to be inhaled into the lungs) mask in a sanitary manner when not in use. This placed the resident at risk for an infection. Findings included: - The Electronic Medical Record for R10 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), anxiety (mental or emotional	F0695		

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F0695 SS = D	Continued from page 15 reaction characterized by apprehension, uncertainty, and irrational fear), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The" Significant Change Minimum Data Set" (MDS), dated 11/22/24, documented R10 had intact cognition. R10 required supervision with bathing and was independent with all other activities of daily living. The MDS further documented R10 received antipsychotic (a class of medications used to treat major mental conditions), antidepressant (a class of medications used to treat mood disorders), and antianxiety (a class of medications used to calm and relax people) medications. The MDS documented R10 did not require supplemental oxygen. The "Quarterly MDS," dated 05/23/25, documented R10 had intact cognition. R10 required supervision with showers and dressing, and was independent with all other activities of daily living. R10 received antipsychotic, antidepressant, and antianxiety medications daily. The MDS further documented R10 received supplemental oxygen. R10's "Care Plan" dated 08/04/25, initiated on 03/03/25, directed staff to monitor for signs or symptoms of respiratory distress and report to the physician as needed. The care plan further directed staff to administer oxygen via nasal cannula at 2 liters per minute at all times. The "Physician's Order," dated 09/15/24, directed staff to administer Oxygen at 2 liters to keep her saturation above 90%. The "Physician's Order," dated 12/04/24, directed staff to administer ipratropium-albuterol (medication to help control symptoms of lung diseases) 0.5 – 2.5 (3) milligrams (mg)/3 milliliters (ml), one vial, inhaled, twice a day for COPD. On 08/18/25 at 09:56 AM, R10's oxygen tubing and cannula were unbagged and draped over the lamp beside her recliner. Further observation revealed the nebulizer mask was unbagged and lying on the table by the recliner. On 08/19/25 at 08:00 AM, R10's nebulizer mask was unbagged and lying on the table by the recliner and was visualized by Licensed Nurse (LN) H.	F0695		

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F0695 SS = D	Continued from page 16 On 08/19/25 at 08:10 AM, LN H stated the oxygen tubing and canula, as well as the nebulizer mask, should always be bagged when not in use. LN H further stated R10 put the tubing over the lamp as her preference and that it should be care planned to do so. On 08/20/25 at 11:01 AM, Certified Nurse Aide (CNA) N stated that when R10 left her room, she personally made sure the tubing was bagged, as they had been provided with bags to store the tubing in. On 08/20/25 at 12:15 PM, Administrative Nurse D stated that the oxygen tubing, as well as the nebulizer mask, should be in a bag when not in use. The facility's "Departmental (Respiratory Therapy)-Prevention of Infection" policy, dated 11/11, directed staff to keep the oxygen cannula, tubing, and nebulizer mask in a plastic bag when not in use.	F0695		
F0756 SS = E	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. §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	F0756		

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F0756 SS = E	Continued from page 17 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 had a census of 34 residents. The sample included 13 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility pharmacist consultant failed to provide the facility with a monthly Drug Regimen Review for February 2025, which placed all residents who received prescribed medications from the facility at risk for less supervision regarding their medication regimen. The facility pharmacist consultant failed to continue to request a gradual dose reduction (GDR) or a physician's rationale and the risks versus benefits for Resident (R) 6's sertraline (antidepressant- a class of medications used to treat mood disorders), for R17's Seroquel (antipsychotic- a class of medications used to treat major mental conditions that cause a break from reality) use, and obtain a stop date for R10's as needed (PRN) Ativan (antianxiety- a class of medication that calm and relax people). Findings included: - The Electronic Medical Record for R17 documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Annual Minimum Data Set" (MDS), dated 12/27/24, documented R17 had severely impaired cognition. R17 required substantial staff assistance for toileting hygiene and personal hygiene. R17 was independent with eating, dressing, mobility, transfers, and ambulation. The MDS further documented R17 received antidepressant (a class of medications used to treat mood disorders)	F0756		

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F0756 SS = E	Continued from page 18 and antianxiety (a class of medications used to calm and relax people) medication daily. The “Quarterly MDS,” dated 06/20/25, documented R17 had severely impaired cognition. R17 required supervision from staff for personal hygiene, eating, oral care, dressing, and set up assistance with mobility and transfers. The MDS further documented R17 received antipsychotic (a class of medications used to treat major mental conditions), antidepressant, and antianxiety medication daily. R17’s “Care Plan” dated 07/02/25, initiated on 02/12/24, directed staff to converse with R17 while providing care, encourage activities, encourage family involvement, and facilitate resident interaction. The care plan update, dated 01/15/24, documented R17 was at risk for adverse reactions from medications with Black Box Warning (BBW- the highest safety-related Warning that medications can have assigned by the Food and Drug Administration) and directed staff to monitor for signs and symptoms of side effects from the medications. The care plan update, dated 01/16/24, directed staff to cue, reorient, and supervise as needed and use task segmentation to support short-term memory deficits. The care plan update, dated 04/07/25, directed staff to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate, at least quarterly. The “Physician’s Order,” dated 01/27/25, directed staff to administer Seroquel (an antipsychotic medication), 12.5 milligrams (mg), by mouth, at bedtime, for anxiety and agitation. The medication was increased to twice per day on 03/07/25. The “Medication Regimen Review,” dated 02/05/25, documented that R17 received the antipsychotic agent Seroquel but lacked an allowable diagnosis to support the use. If continued use of this medication for the indication currently listed in the chart was warranted, please provide a risk versus benefit or discontinue the medication. The Consultant Pharmacist failed to send the recommendations to the facility or the physician; therefore, there was no response from the physician. On 08/19/25 at 03:55 PM, Administrative Nurse D stated the Pharmacist Consultant had forgotten to send the February 2025 "Medication Regimen Reviews" to the facility. Administrative Nurse D stated that, after she received the monthly recommendations, she would send the recommendations to the physician. The facility’s “Pharmacy Services-Role of the	F0756		

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F0756 SS = E	Continued from page 19 Consultant Pharmacist" policy, dated 04/19, documented that the Consultant Pharmacist would review the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated. - R6's "Electronic Medical Record" included diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and major depressive disorder (major mood disorder which causes persistent feelings of sadness). R6's "Quarterly Minimum Data Set" (MDS), dated 05/15/25, documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment, and no mood issues or behaviors. The MDS documented R6 required substantial staff assistance with most activities of daily living. The MDS documented R6 received insulin (a hormone that lowers the level of glucose in the blood), antidepressant (a class of medications used to treat mood disorders), and anticonvulsant (a drug that is used to prevent or treat seizures or convulsions by controlling abnormal electrical activity in the brain) medications. R6's "Care Plan," dated 05/15/25, directed staff to administer medications as ordered. R6's plan of care directed staff to monitor for side effects and effectiveness, initiated 07/12/19. The "Physician Order," dated 07/12/19, directed staff to administer Sertraline (antidepressant medication), 50 milligrams (mg) by mouth daily, related to major depressive disorder, single episode. The Consultant Pharmacist's review on 05/05/25 recommended a gradual dose reduction (GDR) of sertraline or a rationale explaining the decision for continuing the sertraline. No physician response was documented. On 08/19/25, upon request, the consultant pharmacist sent to the facility the February 2025 "Medication Regimen Review," which recommended a GDR, rationale, or risk versus benefit statement for sertraline.	F0756		

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F0756 SS = E	Continued from page 20 On 08/19/25 at 09:15 AM, Licensed Nurse (LN) H administered medications to R6. He took them whole in pudding with water. On 08/19/25 at 03:55 PM, Administrative Nurse D stated the pharmacist consultant had forgotten to send the February 2025 "Medication Regimen Reviews" to the facility. She verified R6's physician would not have received the February 2025 recommendation. Administrative Nurse D verified the physician had not responded to the 05/05/25 recommendation. She verified that the pharmacist consultant sends the monthly reviews to the facility, and she sends them on to each specific physician. She verified the physicians would not have received the February 2025 reports. The facility's "Pharmacy Services" policy, dated April 2019, stated the consultant pharmacist would provide specific activities related to medication regimen review, including: a documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated. The policy documented regular review of the emergency medication supply, review of medication storage areas at least monthly, and medication carts at least quarterly, for proper storage and labeling of medications, cleanliness, and expired medications, and providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review.	F0756		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761		

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F0761 SS = E	Continued from page 21 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 34 residents. Based on observation, interview, and record review, the facility failed to ensure medications were secure when a medication cart was left unlocked and unattended, failed to label and date insulin (a hormone that lowers the level of glucose in the blood) pens when opened, and failed to remove expired medication from use. This deficient practice placed residents at risk of receiving ineffective medication. Findings included: - On 08/18/25 at 09:32 AM, the facility's west medication cart contained: An insulin flex pen without a name or an opened date. A bottle of Aspirin (non-steroidal anti-inflammatory drug- NSAID), 81 milligram (mg) pills, expired 08/2024. Systane (eye lubricant) eye drops, expired 06/2025. Dulcolax (laxative) pills,100 mg, expired 04/2023. On 08/18/25 at 09:45 AM, the facility's east medication cart contained: Two unlabeled, undated insulin pens. A bottle of melatonin (sleep aide) 3 mg pills, expired April 30, 2024. Artificial tears, expired 03/2023. On 08/20/25 at 12:25 PM, the facility's medication room emergency medication kit (E-Kit) had two expired	F0761		

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F0761 SS = E	Continued from page 22 medications: Lidocaine (pain reliever) jelly 2% with expiration date of 07/31/25. Epinephrine (used to treat severe allergic reactions, cardiac arrest, and other conditions) auto-injector 0.3 mg expired 07/31/25. On 08/18/25 at 08:40 AM, Certified Medication Aide (CMA) T verified that the medications in the west medication cart had expired. On 08/18/25 at 09:45 AM, Licensed Nurse (LN) G verified the unlabeled insulin pens and expired medications in the facility's east medication cart. On 08/20/25 at 12:10 PM, Administrative Nurse D verified that staff were to ensure the medication cart was locked when they left it. Staff were to check for and remove expired medications. Staff were to label and date insulin pens when opened. On 08/20/25 at 12:25 PM, CMA RR verified the expiration dates on the E-kit paperwork. On 08/20/25 at 01:20 PM, Administrative Nurse D opened the E-kit and verified that the lidocaine jelly and epinephrine pen were expired. The facility's "Medication Labeling and Storage" policy, dated February 2023, stated that drawers, cabinets, rooms, or carts containing medications and biologicals would be locked when not in use, and carts would not be left unattended if open and potentially available to others. The policy stated medication labels would include the resident's name and expiration date. The facility's "Administering Medications" policy, dated February 2023, stated insulin pens would be clearly labeled with the resident's name. Staff would check the medical label for the expiration date, and when opening a multi-dose container, record the date opened on the container.	F0761		
F0801 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	F0801		

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F0801 SS = F	Continued from page 23 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 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	F0801		

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F0801 SS = F	Continued from page 24 (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 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 34 residents. The facility had one main kitchen and one main dining area. Based on observation, record review, and interview, the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed residents at risk for unmet dietary and nutritional needs. Findings included: - On 08/19/25 at 08:20 AM, Dietary BB stated she did not have her CDM certification, but the administrator and she were currently enrolled in classes to get certified. On 08/19/25 at 10:15 AM, Administrative Staff A stated that the dietary manager and she were currently in classes to get certified as a dietary manager. Administrative Staff A stated the registered dietician came to the facility twice a month, but she was always available by phone. The facility's "Dietician" policy dated July 2025	F0801		

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F0801 SS = F	Continued from page 25 documented if a dietician was not employed full-time, a director of food and nutrition services would be designated. This individual would be a certified dietary manager; or a certified food service manager; or be nationally certified in food service management and safety; or have an associate's degree in food service management or hospitality; or has two 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. The facility failed to ensure the director of food and nutrition services had the required qualifications of a CDM. This placed residents at risk for unmet dietary and nutritional needs.	F0801		
F0849 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 at least the following:	F0849		

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F0849 SS = D	Continued from page 26 (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 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	F0849		

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F0849 SS = D	Continued from page 27 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 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	F0849		

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F0849 SS = D	Continued from page 28 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 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 34 residents. The sample included 13 residents, with two residents sampled for hospice care. Based on observation, record review, and interview, the facility failed to ensure there was a collaboration of care between Resident (R) 2 and R38's hospice provider and the facility which included the information on what hospice would provide the residents. This placed R2 and R38 at risk of inadequate end-of-life care. Findings included: - The Electronic Medical Record (EMR) for R2 had diagnoses of Alzheimer's disease (a progressive mental	F0849		

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F0849 SS = D	Continued from page 29 deterioration characterized by confusion and memory failure), chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The “Significant Change Minimum Data Set” (MMDS), dated 04/16/25, documented R2 had severely impaired cognition. R2 was dependent upon the staff for activities of daily living. The MDS documented R2 received Hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. The” Quarterly MDS,” dated 07/1/25, documented R2 had severely impaired cognition. R2 was dependent upon the staff for activities of daily living. The MDS documented R2 received Hospice services. R2’s “Care Plan” dated 07/17/25, initiated on 04/22/25, documented R2 received hospice services and directed staff to keep the environment quiet and calm, observe for pain, and administer medications as ordered. The care plan lacked instruction on the services provided by hospices, including the frequency of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the address of the chosen hospice. Review of R2's clinical record revealed the resident was admitted to hospice care on 04/11/25. On 08/19/25 at 12:40 PM, R2 sat in a reclined Broda (specialized wheelchair with the ability to tilt and recline), with her eyes closed. On 08/20/25 at 10:15 AM, Licensed Nurse (LN) G stated R2 received hospice services, the nurse came twice per week, as well as a nurse aide. On 08/20/25 at 12:15 PM, Administrative Nurse D stated she would review the care plan to make sure the appropriate information was on the care plan. The facility’s “Hospice Program” policy, dated 07/17, documented that the facility and hospice company would coordinate care provided to the residents. The facility would communicate with hospice representatives to ensure quality of care for the resident and family. The	F0849		

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F0849 SS = D	Continued from page 30 coordinated care plans for the resident receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility. - The “Medical Diagnosis” tab of R38’s Electronic Medical Record (EMR) documented diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), hypertension (HTN- elevated blood pressure), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as the result of pressure, or pressure in combination with shear and/or friction) of the sacral region (area between the posterior hip bones), and osteomyelitis (local or generalized infection of the bone and bone marrow). R38’s “Significant Change Minimum Data Set (MDS)” dated 08/13/25 documented he had a Brief Interview for Mental Status (BIMS) score of seven, which indicated moderately impaired cognition. R38 required substantial to being dependent on staff for his activities of daily living (ADL) cares. R38 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and an ostomy (surgical opening from an area inside the body to the outside). R38 had a Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) pressure ulcer. R38 was on Hospice services. R38’s “Functional Abilities Care Area Assessment (CAA)” dated 08/15/25 documented he was a 61-year-old male admitted to hospice with osteomyelitis of the sacral and sacrococcygeal (area located at the base of the spine) region. R38 presented with a pressure ulcer, Stage 4 of the sacral region (left buttocks), chronic paraplegia, and multiple comorbidities. R38 has severe cognitive impairment. R38’s "Care Plan," revised on 08/15/25, directed staff that R38 had a terminal prognosis related to osteomyelitis and was on hospice services. The Care Plan directed staff to consult with the physician and social services to have hospice care for the resident in the facility. The Care Plan directed staff to keep the environment quiet and calm. The Care Plan directed staff to keep linens clean, dry, and wrinkle-free. The Care Plan directed staff to keep the lighting low and familiar objects close. The Care Plan directed staff to observe R38 closely for signs of pain, to administer pain medications as ordered, and to notify the physician immediately if there was breakthrough pain. The Care Plan directed staff to work cooperatively with the hospice team to ensure the resident's spiritual,	F0849		

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F0849 SS = D	Continued from page 31 emotional, intellectual, physical, and social needs are met. The Care Plan directed staff to work with nursing staff to provide maximum comfort for the resident. The Care Plan lacked staff direction on the durable medical equipment (DME), supplies, and medications provided by hospice. The Care Plan lacked staff direction on what hospice staff would visit and how often those visits would be. R38's "Misc." tab of the EMR was a scanned "Referral Order" dated 08/06/25 for a referral for hospice care. R38's "Misc." tab of the EMR had a scanned "Facility Notification of Hospice Admission/Change" document with an effective date of 08/07/25. R38's "Misc." tab of the EMR documented the "Hospice Certification and Plan of Care" dated for the period of 08/07/25 to 11/04/25. The plan of care documented the frequency/duration of hospice staff visits; orders of discipline and treatments; goals; DME and supplies; functional limitations; safety measures; activities permitted; nutritional requirements; advance directives; mental statuses; allergies; medications; the hospice physician information; and the order description. On 08/18/25 at 11:35 AM, R38 laid on his back on his low air loss mattress (a specialized type of medical mattress designed to prevent and treat pressure ulcers). Staff were preparing to provide care for R38. On 08/20/25 at 09:02 AM, Licensed Nurse (LN) G stated that Administrative Nurse D typically updated the care plans for residents, but the floor nurses could also update the care plans. LN G stated the care plan should list all the hospice information on it. On 08/20/25 at 12:15 PM, Administrative Nurse D stated that when R38 returned to the facility on hospice, his care plan should have been updated to include all the hospice information, which included what equipment, medications, and supplies that hospice provided. Administrative Nurse D stated R38's care plan should also contain the information on what hospice staff would visit and how often. The facility "Hospice Program" policy, dated July 2017, documented the coordinated care plans for residents receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility to maintain the resident's highest practicable physical, mental, and psychosocial well-being.	F0849		

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F0849 F0880 SS=D SS = F	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 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.	F0849 F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK MANOR INC	922 N 5TH ST , LINCOLN, Kansas, 67455

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F0880 SS = F	Continued from page 33 (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 34 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure staff followed appropriate Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) and hand hygiene while providing wound care to Resident (R) 38 and R2. The facility failed to ensure R10's nasal cannula (NC- a hollow tube medical device that provides supplemental oxygen therapy to people who have lower oxygen levels) and nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask was properly stored when not in use. This placed R38, R2, and R10 at risk of infection development and possible respiratory complications. Findings included: - The Electronic Medical Record (EMR) for R2 had diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized	F0880		

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F0880 SS = F	Continued from page 34 by diminished lung capacity and difficulty or discomfort in breathing), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The “Quarterly Minimum Data Set” (MDS), dated 07/11/25, documented R2 had severely impaired cognition. R2 was dependent upon staff for all activities of daily living, had a Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters), and was on received Hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. R2’s “Care Plan,” initiated on 07/12/23, documented R2 had actual skin impairment due to dry skin and limited mobility. The care plan directed staff to follow policies/protocols for the prevention and treatment of skin breakdown, monitor, and report any changes in skin status. The care plan lacked documentation. R2 was on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) and lacked direction to staff on what personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) to use. The "Physician’s Order,” dated 07/22/25, directed staff to apply Opti foam (a brand of foam wound dressing designed to absorb fluid and protect wounds) to her Stage 2 pressure ulcer, change the dressing every seven days and as needed, and discontinue when healed. On 08/20/25 at 10:15 AM, Licensed Nurse (LN) G and LN H sanitized their hands and donned clean gloves. LN G stated R2 had recently gotten a small open area on her coccyx. LN H got on the side of the bed closest to the wall, and LN G was on the opposite side. R2 had bilateral heel protectors on, and LN G pulled down her pants, checked her incontinence brief, and stated she had a bowel movement (bm). R2’s heel protectors and pants were removed due to LN G had gotten BM on her pants while she was providing personal care. Both LN G and LN H removed their soiled glove and donned clean gloves. LN G and LN H assisted R2 onto her left side so that LN H could perform wound care. LN H removed the old dressing, used gauze to cleanse the wound, placed the wound cleanser on the bed, and measured the wound. LN H put Opti foam on R2’s wound, assisted with a clean brief, and still had on soiled gloves. LN H verified	F0880		

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F0880 SS = F	Continued from page 35 that she should have changed her gloves after she cleansed the wound. LN H stated that she had discussed with Administrative Nurse D that R2 needed to be on EBP, and she had not done it yet. LN H stated, it was on her list and would do it right away. On 08/20/25 at 11:00 AM, Certified Nurse Aide (CNA) N stated she did not know that R2 required EBP and that she had never worn a gown while she provided care to R2, only gloves. On 08/20/25 at 12:20 PM, Administrative Nurse D stated R2 should be on EBP due to her open area and that staff should have changed her gloves after she cleaned R2's wound. Administrative Nurse D further stated she would review the care plan and make sure the EBP information was on the care plan. The facility's "Enhanced Barrier Precautions" policy, dated 12/24, documented that EBP is utilized to prevent the spread of multidrug-resistant organisms (MDRO) to residents. Enhanced barrier precautions apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained, and contact precautions do not otherwise apply. EBPs employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities when contact precautions do not otherwise apply. High-contact resident care activities requiring the use of a gown and gloves for EBPs included: dressing, bathing, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, bed mobility, changing linens, and wound care. Signs are posted on the door or wall outside the residents' rooms, which communicate the type of precautions and PPE required. - On 08/18/25 at 11:35 AM, an observation of R38's Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as the result of pressure, or pressure in combination with shear and/or friction) wound care revealed the following: Licensed Nurse (LN) G gathered the wound care supplies to complete R38's wound care. LN G placed a barrier on R38's bedside table and placed all supplies needed on top of the barrier. LN H was in R38's room to assist LN G. LN H performed hand hygiene with hand sanitizer prior to applying clean gloves. LN G applied clean gloves without performing hand hygiene. Neither LN G	F0880		

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F0880 SS = F	Continued from page 36 nor LN H donned a protective gown prior to beginning wound care for R38. LN G raised R38's bed to be at a height appropriate to do wound care. LN G and LN H assisted in rolling R38 to his right side. LN G unfastened R38's brief and then placed a clean barrier under his bottom. LN G removed her gloves and threw them in the trash. LN G then put on a clean pair of gloves (no hand hygiene performed) and began to remove R38's old wound dressings and placed the dressings in the trash can. LN G then grabbed the wound cleanser and cleans the wound area, and wiped with clean 4 x 4 gauze. LN G then started to grab the bottle of packing tape, but stopped and stated, "I guess I should probably change my gloves." LN G removed the dirty gloves and put on a clean pair of gloves (no hand hygiene performed). LN G continued to perform the wound care as ordered. LN G gathered the trash after the task was completed and removed her gloves. LN G failed to perform hand hygiene after disposing of the trash. LN H removed her gloves and performed hand hygiene before leaving R38's room. On 08/18/25 at 11:50 AM, LN G stated she should have washed her hands and done hand hygiene after removing her gloves. LN G stated that a gown should have also been worn while providing cares to R38. On 08/20/25 at 12:15 PM, Administrative Nurse D, the facility's Infection Preventionist, stated the staff had just had an education session with staff about the EBP. Administrative Nurse D stated staff should know to always wear gloves and gowns when providing a resident on EBP as well as doing hand hygiene in between glove changes. The facility's "Enhanced Barrier Precautions" policy dated December 2024 documented EBPs were utilized to prevent the spread of multidrug-resistant organisms (MDRO) to residents. EBP applies when a resident was infected with a Centers for Disease Control and Prevention (CDC)- targeted MDRO. EBPs employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities when contact precautions do not otherwise apply. Gloves and a gown are applied prior to performing the high-contact resident care activity. Examples of high-contact resident activities requiring the used of gown and gloves for EBPs included: dressing bathing/showering; providing hygiene or grooming changing briefs or assisting with toileting; transferring; providing bed mobility; changing linens; prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin' device care or use; and wound care.	F0880		

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F0880 SS = F	Continued from page 37 The undated facility's "Handwashing/Hand Hygiene" policy documented all personnel were trained and regularly in-service on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel were expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies were readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol based hand-rub (ABHR) dispensers were placed in areas of high visibility and consistent with workflow throughout the facility. All personnel were to perform hand hygiene before applying non-sterile gloves. After removing gloves, perform hand hygiene.	F0880		