STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175549	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS REHAB & HEALTH CARE CENTER	**12340 QUIVIRA ROAD , OVERLAND PARK, Kansas, 66213**

(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 resurvey and complaint investigation 2610354. The 2567 was sent electronically on 11/17/25.	F0000		
F0550 SS = D	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 from the facility.	F0550		

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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F0550 SS = D	Continued from page 1 §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 reported a census of 57 residents. The sample included 15 residents reviewed for dignity. Based on observations, interviews, and record review, the facility failed to ensure a dignified care environment for Resident (R) 8 when staff spoke to her in a disrespectful manner when the resident asked for assistance Findings Included: - R8's Electronic Medical Records (EMR) included diagnoses of depression, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, and dysphagia (difficulty swallowing). R8's "Quarterly Minimum Data Set (MDS)" completed 07/31/25 indicated a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted upper extremity impairment on one side. The MDS noted she required substantial to maximal assistance for transfers, bathing, dressing, toileting, bed mobility, personal hygiene, and putting on footwear. The MDS noted she was frequently incontinent of urine. The MDS noted she had one non-injury fall since admission. R8's "Functional Abilities Care Area Assessment (CAA)" completed 12/13/24 indicated she required staff assistance for her activities of daily living. The CAA noted she was to anticipate her needs to prevent falls, skin breakdown, incontinence, and potential decline in her activities. R8's "Care Plan" initiated 12/06/25 indicated she required assistance from one staff member for bed mobility, dressing, toileting, transfers, bathing, and putting on her footwear. The plan noted she was at risk for falls. The plan instructed staff to anticipate her needs, keep personal items within reach, and encourage her to use her call light before transferring. The plan	F0550		

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F0550 SS = D	Continued from page 2 indicated she was to have a “Call, Don’t Fall” sign in her room. A review of the facility’s “Monthly Grievance Logs” indicated R8 filed a grievance on 09/10/25 related to Certified Nurse’s Aide (CNA) M’s conduct. A review of the grievance report revealed it was documented as a staff concern. The grievance indicated CNA M was repeatedly rude to R8. The grievance indicated that CNA M told R8 that all the direct care staff did not like her because she had to go to the bathroom too much. The report indicated CNA M denied making the comment, but indicated she was short with R8 and had not provided good customer service. The report indicated CNA M was given corrective action and instructed not to provide care for R8. The note indicated R8 felt safe. The report indicated R8’s family felt safe with the resolution on 09/12/25. On 09/30/25 at 01:20 PM, members of the facility’s resident council indicated R8 struggled with being bullied by CNA M. The council report concerns that the facility did not talk to R8 about how the incident affected her. On 09/30/25 at 01:40 PM, R8 asked to talk about CNA M and became tearful. R8 indicated she asked for help from staff to use the bathroom. and said CNA M entered her room and told he she would have to wait to go to the bathroom, and indicated to the resident that staff were upset that the resident was wet all the time. R8 reported that it made her feel like a burden to staff, and she said she did not want to be around people who did not like her. On 09/30/25 at 02:00 PM, Administrative Staff A was notified, and he stated that he had the facility immediately suspend CNA M. He stated he had no awareness of R8’s potential psychosocial trauma, but the facility would immediately screen R8. On 09/30/25 at 02:20 PM, Certified Nurse’s Aide (CNA) N stated that staff were expected to treat all residents with respect and dignity. She stated any rudeness from staff would be reported immediately to Administrative Staff A and Administrative Nurse D. On 09/30/25 at 02:00 PM, Administrative Nurse A stated that staff were trained annually and frequently on resident rights, dignity, and abuse topics. She stated that staff were expected to be polite and respectful to all residents. The facility’s “Resident Rights” policy (undated)	F0550		

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F0550 SS = D	Continued from page 3 indicated the facility was to ensure all residents were treated in a dignified manner. The policy indicated the facility was to provide ongoing education and In-service.	F0550		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by:	F0578	"Past Noncompliance - no plan of correction required"	

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F0578 SS = D	Continued from page 4 The facility reported a census of 57 residents. The sample included 15, with one reviewed for advance directives. Based on observations, interviews, and record review, the facility failed to follow Resident (R) 59's chosen advanced directives (legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves) related to her do not resuscitate (DNR) wishes for cardio pulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating). Findings Included: - R59's Electronic Medical Records (EMR) included diagnoses of muscle weakness, atrial fibrillation (rapid, irregular heartbeat), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), heart failure, and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R59's "Admission Minimum Data Set (MDS)" completed 09/03/25 indicated a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted no upper or lower extremity impairments. The MDS noted she required moderate to substantial assistance with bathing, dressing, bed mobility, personal hygiene, and toileting. The MDS noted she was continent of bowel and bladder. R59's "Cognitive Loss Care Area Assessment (CAA) " completed 08/29/25, noted she triggered related to her poor insight, reduced memory recall, and poor safety judgment. The CAA noted that a plan of care was implemented to address her potential risks related to her cognitive decline. R59's "Care Plan" initiated 08/29/25 indicated her advanced directives listed her as a DNR on 08/29/25. The plan instructed staff to honor her advanced directives and end-of-life decision. R59's EMR under "Miscellaneous" revealed a "Do Not Resuscitate Directive" signed by R59 and her medical provider on 08/29/25. R59's EMR under "Physicians Orders" revealed she had a DNR order started on 08/29/25. A "Facility Incident Report #0354" completed on	F0578		

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F0578 SS = D	Continued from page 5 09/08/25 indicated R59 was found unresponsive by staff on 09/07/25 at 04:55 PM. The report indicated that the staff noted her nursing report sheet indicated she was a full code. The report revealed staff began CPR on R59 without verifying R59's advanced directives in her EMR. At 04:57 PM, Emergency medical services (EMS) arrived and took over CPR. The report indicated R59's pulse returned, and she was transported to an acute medical facility for treatment. On 09/30/25 at 01:20 PM, Certified Nurse's Aide (CNA) N stated she would check the care plan with the nurse to verify a resident's code status. On 09/30/25 at 01:27 PM, Licensed Nurse (LN) G stated staff were expected to check either the orders or the care plan for updated advanced directives. She stated the forms were signed upon admission and updated for the care plan, Kardex (nursing tool that gives a brief overview of the care needs of each resident), and orders. She stated that direct care staff were expected to check with the nurse during emergencies. On 09/30/25 at 02:00 PM, Administrative Nurse A stated that staff were expected to verify the code status of each resident in the care plan or orders before attempting CPR. She stated that if changes were made to a resident's code status, it was immediately relayed to the team. The facility did not provide a policy related to advance directives as requested on 09/30/25. The facility implemented the following corrective actions related to this incident: 1. The facility completed an audit of current residents to verify the appropriate code statuses for each resident on 09/07/25. 2. The facility completed staff education for all direct care staff related to advanced directives and where the appropriate place to find the code status for each resident on 09/07/25. 3. The facility will complete five staff interviews weekly to ensure staff knowledge of advanced directives starting on 09/07/25. 4. The facility will complete practice "codes" weekly on alternating shifts to ensure staff knowledge for six weeks starting on 09/07/25. 5. The facilities Quality Assurance team reviewed the	F0578		

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F0578 SS = D	Continued from page 6 results of the audits and interviews to ensure ongoing compliance starting on 09/07/25. This deficient practice was deemed as past non-compliance when the facility implemented the following corrective actions on 09/07/25, prior to the surveyor entering the facility.	F0578		
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 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.	F0605		

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F0605 SS = D	Continued from page 7 §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 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	F0605		

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F0605 SS = D	Continued from page 8 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 57 residents. The sample included 15 residents, with five reviewed for unnecessary drugs. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 6 was free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use without a proper indication for use written by the physician. Findings included: - R6‘s Electronic Medical Record (EMR) documented diagnoses of neurocognitive disorder with Lewy bodies (a type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function) and a cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R6‘s “Admission Minimum Data Set” (MDS) dated 08/23/25 documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented R6 required maximum or full staff assistance with activities of daily living and received antipsychotic medication. R6‘s “Psychotropic Drug Use Care Area Assessment" (CAA) dated 08/23/25 stated R6 was at risk for side effects due to the daily use of quetiapine (an antipsychotic). R6‘s “Care Plan” dated 08/18/25 included the Black Box	F0605		

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F0605 SS = D	Continued from page 9 Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) for quetiapine which stated elderly patients with dementia (progressive mental disorder characterized by failing memory, confusion)-related psychosis treated with antipsychotic drugs were at an increased risk of death and quetiapine was not approved for the treatment of patients with dementia-related psychosis. The care plan directed staff to request the physician review and evaluate medications, review pharmacy consult recommendations, and follow up. The “Physician Order” dated 08/17/25 directed staff to administer quetiapine, 25 milligrams (mg) by mouth at bedtime, for mood disorder. R6’s September 2025 “Medication Administration Record (MAR)” for antipsychotic medication monitoring lacked documentation of any abnormal behaviors. R6’s EMR lacked a written physician rationale for the use of an antipsychotic, quetiapine, without an approved indication of use. On 09/29/25 at 07:20 AM, Certified Medication Aide (CMA) R administered medications to R6 in his room. He took the pills whole without problems and was polite and thanked the CMA R. On 09/30/25 at 02:19 PM, Administrative Nurse D verified the pharmacist's recommendation included choices for the physician to indicate the use of quetiapine, and the physician did not write a rationale for the use of the unapproved antipsychotic. She stated psychiatry had not been to the facility to assess the resident. The facility’s “Psychotropic (alters mood or thought) Medication Use” policy, dated February 2025, stated residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. The policy stated antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders: Schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), Tourette's Disorder (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds), or Huntington Disease (rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous	F0605		

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F0605 SS = D	Continued from page 10 system movement disorder). Diagnoses alone do not warrant the use of psychotropic medication.	F0605		
F0686 SS = D	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 had a census of 57 residents. The sample included 15 residents, with six residents reviewed for pressure ulcers (PU- 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). Based on observation, interview, and record review, the facility failed to thoroughly assess Resident (R) 41's Stage three PU (full-thickness pressure injury extending through the skin into the tissue below) and Stage four PU (a deep pressure wound that reaches the muscles, ligaments, or even bone). Findings included: - R41's Electronic Medical Record (EMR) documented a diagnosis of osteomyelitis (infection of the bone and bone marrow) of the sacrococcygeal region (area at the very base of the spine), encompassing the sacrum (a triangular bone) and the coccyx (the tailbone). R41's "Admission Minimum Data Set" (MDS), dated 09/25/25, was in progress. R41's "Care Plan" dated 09/19/25 documented R41 had an actual pressure injury to his left gluteus (buttocks muscle) and right heel.	F0686		

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F0686 SS = D	Continued from page 11 R41's "Physician Order" dated 09/22/25 directed staff to provide wound care to R41's right heel and left gluteus, ensure heel protectors were on while he was in bed, provide a low air loss mattress, and have Wound Care Plus evaluate and treat R41. R41's "Skin Assessment" dated 09/22/25 included measurements of the gluteal PU, 3.5 centimeters (cm) by 2.7 cm by 0.3 cm deep when the resident returned from the hospital. The assessment lacked documentation of the characteristics of the PUs. R41's "Skin Assessment" dated 09/29/25 documented the gluteus PU measured 18.1 cm by 5.5 cm. The right heel PU measured 3.5 by 2.7 cm. The assessment lacked depth measurement or characteristics of the wound. The facility lacked documentation the physician was informed of the increased size of the PU. On 09/29/25 at 01:33 PM, Licensed Nurse (LN) F and LN I performed wound care for R41's PUs. The nurses washed hands and donned personal protective equipment (PPE-gowns, face shields, and/or eyeglasses/goggles, and gloves) prior to the wound care. LN F cleaned the gluteus wound, which was approximately two to three cm deep, and five cm long by five cm wide. LN F took a picture for the measurements, but did not measure the depth. LN F applied collagen to the wound bed and covered it with a silicone-faced dressing. LN F also provides wound care to R41's right heel. On 09/30/25 at 02:36 PM, Administrative Nurse D stated R41 was admitted with pressure ulcers on 09/17/25. She verified staff were to measure and assess PU weekly and document the results. She stated R41's physician had been notified of the increase in size, but the facility did not have documentation. The facility's "Pressure Injury Assessment and Treatment Guideline," dated January 2025, documented the following information should be recorded in the resident's electronic medical record: type of wound and location, stage of the pressure wound, wound measurements, undermining or tunneling, drainage or odor. Staff were to document assessment of the wound bed, including type and amount of tissue visualized, the wound edges, and the surrounding tissue.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689		

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F0689 SS = D	Continued from page 12 §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 reported a census of 57 residents. The Sample included 15, with three reviewed for falls. Based on observations, record review, and interviews, the facility failed to implement Resident (R) 8's fall interventions related to fall prevention signs. Findings Included: - R8's Electronic Medical Records (EMR) included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, and dysphagia (difficulty swallowing). R8's "Quarterly Minimum Data Set (MDS)" completed 07/31/25 indicated a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted upper extremity impairment on one side. The MDS noted she required substantial to maximal assistance for transfers, bathing, dressing, toileting, bed mobility, personal hygiene, and putting on footwear. The MDS noted she was frequently incontinent of urine. The MDS noted she had one non-injury fall since admission. R8's "Functional Abilities Care Area Assessment (CAA)" completed 12/13/24 indicated she required staff assistance for her activities of daily living. The CAA noted she was to anticipate her needs to prevent falls, skin breakdown, incontinence, and potential decline in her activities. R8's "Care Plan" initiated 12/06/25 documented she required assistance from one staff member for bed mobility, dressing, toileting, transfers, bathing, and	F0689		

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F0689 SS = D	Continued from page 13 putting on her footwear. The plan noted she was at risk for falls. The plan instructed staff to anticipate her needs, keep personal items within reach, and encourage her to use her call light before transferring. The plan indicated she was to have a “Call, Don’t Fall” sign in her room. On 09/29/25 at 07:22 AM, an inspection of R8’s room revealed no “Call Don’t Fall” sign in place in her room or bathroom. R8 was unable to locate the signs in her room. On 09/30/25 at 09:00 AM, an inspection of R8’s room revealed no “Call Don’t Fall” sign in place in her room or bathroom. On 09/30/25 at 01:20 PM, Certified Nurse’s Aide (CNA) N stated that fall signs were usually placed by the bed or toilet to prevent the residents from self-transferring. On 09/30/25 at 02:00 PM, Administrative Nurse A stated nurses were responsible for ensuring the fall interventions were implemented in the resident rooms. She stated the interdisciplinary team reviewed the intervention effectiveness weekly, and the interventions were expected to be implemented immediately to prevent falls. The facility’s “Accidents” policy, revised (undated), stated that the facility would ensure a safe environment for all residents. The policy indicated staff would assess each resident’s potential risks, including functional abilities, potential falls, assistive devices, and environment, to ensure resident safety.	F0689		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 57 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to ensure	F0698		

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F0698 SS = D	Continued from page 14 Resident (R) 3 received care and services for dialysis (a procedure where impurities or wastes were removed from the blood) consistent with professional standards of practice, which include ongoing communication and collaboration with the dialysis facility. Findings included: - R3's Electronic Medical Record (EMR) included diagnoses of acute osteomyelitis (local or generalized infection of the bone and bone marrow) of the left foot and ankle, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), non-pressure chronic ulcer, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), end-stage renal disease, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), muscle weakness, and fatigue. R3's "Admission Minimum Data Set" (MDS) dated 08/21/25 documented that R3 had intact cognition, functional range of motion limitation in both upper and lower extremities and used a wheelchair. R3 required substantial to maximal assistance with eating, oral care, personal hygiene, and upper body dressing. R3 was dependent on toileting, bathing, lower body dressing, rolling side to side in bed, sitting to lying and lying to sitting, sitting to standing, and transfers. The MDS further documented that R3 had pain almost constantly, unhealed pressure ulcers (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) present upon admission, and a surgical wound. R3 received nutrition or hydration interventions to manage skin problems, pressure and surgical wound care, application of nonsurgical dressings other than to the feet, and application of dressing to the feet. The "Dehydration/Fluid Maintenance Care Area Assessment" (CAA) dated 08/22/25 documented R3 had a Multidrug-Resistant Organism (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) of the left ankle wound and received antibiotic therapy while at dialysis after the treatment. R3's "Care Plan" dated 08/16/25 documented R3 needed hemodialysis (a procedure where impurities or wastes are removed from the blood) related to renal failure. A	F0698		

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F0698 SS = D	Continued from page 15 "Care Plan" revision, dated 08/21/25, directed staff to fill out a communication sheet and send it with R3 to dialysis and ensure that it is returned and completed. The "Physician Order" dated 09/16/25, directed staff to fill out the Dialysis Communication sheet and send it with R3 to dialysis and ensure that it was returned and completed. Upon review of the Dialysis Communication Form (which states to utilize each visit and then scan it into the EMR), the facility failed to provide the portion of the form's "Resident Condition" on 08/19/25, 08/30/25, 09/02/25, 09/09/25, 09/16/25, 09/20/25, and 09/27/25. On 09/30/25 at 10:00 AM, staff assisted R3 with transferring into a wheelchair for travel to the dialysis center. On 09/30/25 at 03:49 PM, Administrative Nurse D and Licensed Nurse (LN) H verified that the facility staff were to provide information on the resident's condition on the Dialysis Communication Sheet and had failed to do so on the dates previously noted. The facility's "Dialysis Communication" policy, dated 12/2024, documented that a dialysis communication form would be used to send information to and from the facility to the dialysis center and back. The nurse in charge of the care of the resident on the days scheduled for dialysis shall initiate the dialysis communication form and ensure the form is sent with the resident.	F0698		
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 §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	F0761		

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F0761 SS = E	Continued from page 16 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 57 residents. The facility had six medication carts and two medication rooms. Based on observation, interview, and record review, the facility failed to remove outdated or expired medication from potential administration to residents. Findings included: - On 09/29/25 at 07:42 AM, the “Blue” Medication cart contained two expired medications: Heartburn relief liquid antacid, 12 fluid ounces, with the expiration date of 10/2024. Vitamin D3, 50 micrograms (mcg), bottle of soft gels, expired April 2023. On 09/30/25 at 09:00 AM, the “Blue” medication room had an emergency kit box with two vials of Ativan (antianxiety drug) with an expiration date of 07/2024. On 09/29/25 at 07:45 AM, Certified Medication Aide (CMA) S verified the expiration dates on the medications. On 09/30/25 at 09:00 AM, Administrative Nurse F verified the expiration dates on the two vials of Ativan. On 09/30/25 at 09:22 AM, Administrative Nurse D verified the pharmacist should have removed the expired vials of Ativan medication from service. She verified staff should have removed the non-narcotic expired medications from service. The facility’s “Medication Storage in the Facility” policy, dated May 2019, documented that outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled, or without a secure closures would be immediately withdrawn from stock by the facility. They would be disposed of	F0761		

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F0761 SS = E	Continued from page 17 according to drug disposal procedures and reordered from the pharmacy if a current order exists.	F0761		
F0880 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 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	F0880		

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F0880 SS = E	Continued from page 18 (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 57 residents. The facility identified 15 residents 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). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control practices related to wearing personal protective equipment (PPE) related to residents on EBP. Findings Included: - On 09/30/25 at 07:36 AM, Certified Nurse Aide (CNA) M and CNA N used a total lift to transfer Resident (R) 23, who had wounds and a urinary catheter, from his bed to a wheelchair. The CNAs did not wear gowns for infection control during the transfer. On 09/30/25 at 07:45 AM, Licensed Nurse (LN) G verified staff should have worn gowns when transferring R23, as his physician ordered on 09/26/25.	F0880		

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F0880 SS = E	Continued from page 19 On 09/30/25 at 02:32 PM, Administrative Nurse E verified that staff should have worn gowns during the transfer. The facility's "Infection Prevention and Control Manual Enhanced Barrier Precautions" policy, undated, stated Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) in nursing homes. EBP involved gown and gloves used during high-contact resident care activities for residents at increased risk for MDRO acquisition (such as residents who have wounds or indwelling medical devices). EBP expands the use of a gown and gloves to focus on resident care activities that have been demonstrated to result in the transfer of MDROs to the hands and clothing of healthcare personnel. - Resident (R) 13's Electronic Medical Record (EMR) documented diagnoses of urinary tract infection (UTI- an infection in any part of the urinary system), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), acute kidney failure, retention of urine, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R13's "Admission Minimum Data Set" (MDS) dated 09/22/25 documented R13 had intact cognition, had functional range of motion impairment of both lower extremities, and used a wheelchair. R13 was dependent on staff for toileting, bathing, lower body dressing, rolling side to side in bed, and sit-to-stand transfers. R13 required partial to moderate assistance with upper body dressing and chair/bed transfers. The MDS further documented that R13 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and a UTI in the past 30 days. R13's "Urinary Incontinence Care Area Assessment" (CAA) dated 09/26/25 documented R13 had two nephrostomy (an artificial opening created between the kidney and the skin which allows for the urinary diversion) tubes and a suprapubic (urinary bladder catheter inserted through the abdomen into the bladder) catheter. R13's "Feeding Tube (g-tube- the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) CAA" dated 09/26/25 documented R13 had a feeding tube that was only used for flushing each shift.	F0880		

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F0880 SS = E	Continued from page 20 R13's "Care Plan" dated 09/16/25 documented that R13 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) due to catheters, nephrostomy, and g-tube. The Care Plan directed staff to wash/sanitize hands before entering the room and when leaving the room, and to wear a gown and gloves when performing high-contact activities. The "Physician Order" dated 09/18/25 directed staff to use EBP with dressing, bathing, transfers, changing linens, providing hygiene, toileting or peri care, device care, or wound care. On 09/30/25 at 10:25 AM, Licensed Nurse (LN) J prepared R13's medication for administration through the g-tube. LN J sanitized hands by using alcohol gel, placed gloves on, and entered the room. R13's door had a sign with information regarding EBP and a clear plastic pocket container with blue plastic gowns. LN J proceeded to administer medications and water through the g-tube without wearing a protective gown. On 09/30/25 at 01:03 PM, LN J verified that gloves and gowns should be worn during the administration of medications through R13's g-tube. On 09/30/25 at 01:25 PM, Administrative Nurse D and LN H both verified R13 had EBP, and the use of gloves and gowns were to be worn while administering g-tube medications. The facility's undated "Infection Prevention and Control Manual-Enhanced Barrier Precautions" policy documented EBP as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) in nursing homes. EBP expands the use of gowns and gloves beyond anticipated blood and body fluid exposures. EBP is recommended for residents with any of the following: infection or colonization with an MDRO or a wound or indwelling medical device, even if the resident is not known to be infected or colonized with an MDRO. Indwelling medical devices include central venous (blood vessel) catheters, urinary catheters, feeding tubes, or tracheostomies (opening through the neck into the trachea through which an indwelling tube may be inserted)/ventilators (a medical device that provides breath to persons who cannot breathe on their own).	F0880		