STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175559	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN PRAIRIE SENIOR LIVING LLC	**510 E SAN JACINTO AVENUE , ULYSSES, Kansas, 67880**

(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 citations on the 2567 represent the findings of a Partial Extended Health Recertification Survey and complaint survey regarding allegations in 2640799.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents, the sample included 12 residents. Based on interview and record review, the facility failed to inform Resident (R) 17 and/or her representative regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included: - R17's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder	F0552		

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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F0552 SS = D	Continued from page 1 characterized by failing memory and confusion), psychotic disorder (any major mental disorder characterized by a gross impairment in reality perception), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). R17's 11/05/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R17's MDS documented she had minimal depression and hallucinations (perceptual experiences in the absence of real external sensory stimuli), and delusions (misconceptions or beliefs that are firmly held, contrary to reality) during the look-back period. The MDS documented no behaviors. The MDS documented R17 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders). R17's 11/12/25 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R17 was alert, oriented, and able to make herself understood and understand others. She had a diagnosis of dementia, a psychotic disorder with hallucinations. R17 received fluvoxamine (an antidepressant) and risperdal (an antipsychotic). Nursing staff would monitor for effectiveness and possible adverse reactions. The resident had feelings of sadness more than half the days. She stated she would "be better off dead" and related these feelings to the hallucinations she was having. She would continue to be followed by a behavioral health provider. R17's "Care Plan" dated 02/01/24 instructed staff to monitor R17 for any side effects from antidepressant medications such as sedation, drowsiness, dry mouth, blurred vision, urinary retention (lack of ability to urinate and empty the bladder), tachycardia (rapid heartbeat greater than 100 beats per minute), muscle tremor, agitation, headache, skin rash, photosensitivity, and excess weight gain. R17's "Care Plan" revised date 10/30/25 instructed staff to monitor R17 for any side effects from antipsychotic medications such as tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs,	F0552		

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F0552 SS = D	Continued from page 2 and trunk), dry mouth, constipation, blurred vision, drowsiness, weight gain, increased risk of obesity, elevated blood glucose and high cholesterol, restlessness, stiffness, tremors and muscle spasms, contraction of the muscles of the neck, eyes, tongue, jaw and other muscle groups, and unsteady gait. R17's EMR documented an order for fluvoxamine 50 milligrams (mg) every evening for major depressive disorder dated 09/04/25. R17's clinical record lacked evidence of informed consent related to the medication. R17's EMR documented an order for risperidone 0.5 mg twice daily for dementia dated 11/20/25. R17's clinical record lacked evidence of informed consent related to the medication. R17's EMR documented an order for risperidone 0.25 mg twice daily for dementia dated 11/20/25. R17's clinical record lacked evidence of informed consent related to the medication. During an interview on 12/03/25 at 10:01 AM, Licensed Nurse (LN) G reported that Administrative Nurse E would obtain the consents for psychoactive medications from the resident or their representative. During an interview on 12/03/25 at 11:07 AM, Administrative Nurse E reported no consent was completed for R17's fluvoxamine or risperdal as of 12/03/25. Administrative Nurse E reported that a consent for psychoactive medications should have been completed when R17 was started on fluvoxamine and risperdal in September 2025, when ordered. The facility's policy "Psychoactive Medications" dated 12/04/24, documented psychoactive medications include antipsychotics and antidepressants. Prior to initiating or increasing a psychotropic medication, the resident, their family, and/or the resident's representative must be informed of the benefits of the medication, the risks of the medication, including any black box warning for any antipsychotic medications, and alternatives for the medication. A written consent form would serve as evidence of the resident's consent to psychotropic medication.	F0552		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment	F0584		

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F0584 SS = E	Continued from page 3 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by:	F0584		

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F0584 SS = E	Continued from page 4 The facility reported a census of 33 residents. Based on observation, record review and interviews, the facility failed to promote a comfortable, sanitary, and homelike environment when the temperature in the activity room was below comfortable level, and chairs in the common area were worn with visible cushion-stuffing on the arms. Finding included: - During an observation on 12/01/25 at 07:33 AM, two green chairs by the 200-hall entrance had worn fabric on the arms of the chairs showing white stuffing. During an observation on 12/01/25 at 09:40 AM, Resident(R) 30, a nonverbal resident, sat in the activity room watching television, wrapped in a blanket. The room felt chilly, and upon assessment of the temperature, the ambient room temperature was approximately 64 degrees Fahrenheit (F). Further observation revealed a sign above the thermostat which directed to keep the thermostat between 70-75 degrees F. In an interview on 12/01/25 at 09:41, Administrative Staff A stated the activity room was on the cooler side of the building. Administrative Staff A approached the thermostat and increased it to 76 degrees F. On 12/01/25 at 10:00 AM, Administrative Staff A confirmed the temperature in the activity room was inadequate and said the facility would contact a service company to assess the situation. In an interview on 12/03/25 at 12:27 PM, Administrative Staff A stated the green chairs in the 200-hall lobby did have worn-down fabric and went on to say she did not think the surface of the chair arms was cleanable. On 12/02/25 at 11:56 AM, Administrative Staff stated she received an email confirmation from the service company confirming the heating valves had been closed, so no hot water was flowing through the coils. The service company opened the hot water valves and closed the cooling valves, and verified the units were heating like they should and were functioning properly at that time.	F0584		

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F0584 SS = E	Continued from page 5 The facility did not provide a policy.	F0584		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents; the sample included 12 with one resident reviewed for prevent decrease in range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) and mobility. Based on observation, interview, and record review, the facility failed to provide a hand carrot (most commonly refers to a hand contracture [abnormal permanent fixation of a joint or muscle] device, a tapered, carrot-shaped medical device used to position fingers away from the palm in cases of severe hand spasticity or contraction) to Resident (R) 8. Findings included: - R8's Electronic Medical Record (EMR) revealed diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and chronic pain. R8's 03/14/25 "Annual Minimum Data Set" (MDS)	F0688		

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F0688 SS = D	Continued from page 6 documented a Brief Interview for Mental Status (BIMS) of nine, which indicated moderately impaired cognition. R8's MDS recorded impairment to one side of her upper and lower extremities. The MDS recorded R8 required total dependence of all activities of daily living (ADLs). R8's 03/28/25 " Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented she was dependent on staff for ADLs and mobility needs due to hemiplegia and hemiparesis following a cerebrovascular accident affecting the left non-dominant side. R8 was participating in restorative therapy to maintain her strength and ROM. R8's "Care Plan" instructed staff that she was participating in restorative therapy to maintain functioning by doing ROM to her extremities three to six days a week. Staff were instructed to apply a hand carrot to keep the left hand in a more open position. Staff were instructed R8 could complete active ROM with prompting, but required passive ROM for her left extremities. R8's "Physician Orders" lacked documentation for ROM or a hand carrot. R8's "Restorative Aide Task" documented a hand carrot was to be applied daily. The task review for the last 30 days revealed the carrot was documented eight times as non-applicable, and on 11/08/25 and 11/27/25, the record lacked any documentation regarding the application of the carrot. R8's "Restorative Progress Note" on 5/23/2025 at 03:58 documented R8 was participating in restorative therapy to maintain functioning by doing ROM to her extremities three to six days a week for at least 15 minutes per day. She participated well with frequent prompting. She was able to perform active ROM to the right extremities, but had passive ROM to the left side. A hand carrot was also added to the left hand due to contracting. R8's "Restorative Progress Note" on 11/25/2025 at 10:14 AM documented R8 was participating in restorative therapy to maintain functioning by doing ROM to her extremities three to six days a week and was also using	F0688		

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F0688 SS = D	Continued from page 7 a "hand carrot" to keep her left hand in a more open position. During an observation on 12/01/25, 8:15 AM, R8 sat in a wheelchair with a green lift sling under her. A blue colored right arm support was on her wheelchair, and her left hand was clenched shut with no device or carrot observed in her hand. During an observation on 12/02/25 at 7:35 AM, R8 sat in a wheelchair in the lobby. Her left hand remained tightly closed, with no device or carrot observed in her left hand. During an observation on 12/02/2025 at 03:50 PM, R8 laid in her bed with her eyes closed. R8 did not have a hand carrot noted in her left hand. She was unable to open her left hand when asked. During an observation on 12/03/2025 at 07:50 AM, R8 sat in a wheelchair in the lobby. Her left hand remained tightly closed with no device or carrot observed in her left hand. During an observation on 12/03/2025 at 09:24 AM, R8 sat in a wheelchair in the exercise room with several other residents. R8 had a left-hand carrot in place. During an interview on 12/02/25 at 03:54 PM, Certified Medication Aide (CMA) R reported that CNA O was the Restorative Aide and was the only staff member to apply the hand carrot. During an interview on 12/02/25 at 04:21 PM, CNA O reported that R8 should have the left-hand carrot applied every day for one to two hours on Monday through Saturday, as no restorative was completed on Sundays. CNA O reviewed the documentation in the EMR and reported that she would document non-applicable if the resident was asleep and reported that R8 slept a lot. During an interview on 12/02/25 at 04:29 PM, Licensed Nurse (LN) G reported that R8 would wake up easily and let the staff take care of her, then R8 would fall back to sleep. LN G reported that Administrative Nurse E	F0688		

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F0688 SS = D	Continued from page 8 would monitor the restorative aide's work. During an interview on 12/03/25 at 10:04 AM, Administrative Nurse E reported that she instructed CNA O to document non-applicable if the residents were asleep. Administrative Nurse E reviewed the documentation in EMR and reported she did not realize that R8 had a lot of non-applicable documentation for the hand carrot. Administrative Nurse E reported that she had mistakenly entered the hand carrot in EMR tasks. Administrative Nurse E said she changed it today to three to six times a day. She reported she did not think that R8 was missing that many days of having the hand carrot placed. During an interview on 12/03/25 at 10:21 AM, Administrative Nurse D reported she expected the restorative aide to complete all the residents' tasks daily and reported that if the resident was asleep, the resident should be re-approached when awake. The facility's policy "Restorative Nursing" dated 11/18/2017 documented residents will receive restorative nursing services to promote the ability to adapt and adjust to living independently and safely as possible. A restorative nursing program would be utilized to maintain and/or improve range of motion, mobility, and ADL skills.	F0688		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents which included a sample of 12 residents and one resident reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to	F0689		

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F0689 SS = D	Continued from page 9 ensure an environment free from accident hazards when staff failed to provide adequate supervision which allowed Resident (R) 1 to exit the facility without staff knowledge or supervision. Findings included: - R1's Electronic Health Record (EHR) documented R1 had diagnoses which included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), adjustment disorder (a condition characterized by an excessive emotional or behavioral response to a stressful event or change in a person's life) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R1's 10/29/25 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The assessment documented rejection of care occurred one to three days, and wandering behaviors occurred four to six days during the look-back period. R1 was dependent on staff for all cares except eating, which was performed independently. R1 was independent with locomotion and transfers except toilet transfers, which required supervision. The 10/29/25 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R1 had diagnoses that included Alzheimer's and dementia with wandering and rejection of care behaviors. Staff would redirect and provide frequent monitoring. The 10/29/25 "Behavioral Symptoms CAA" documented R1 had diagnoses that included Alzheimer's and dementia, and had behaviors that included frequent wandering. R1 wandered into other residents' rooms. Staff would frequently monitor R1 and provide redirection and distraction. R1 had an elopement bracelet in place (a bracelet that helps monitor residents who are at risk of wandering). R1's "Care Plan", documented on 10/23/25, R1 was at risk for elopement and provided the following interventions:	F0689		

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F0689 SS = D	Continued from page 10 Staff would ensure R1's elopement bracelet was on and functioning properly every shift, created and initiated on 10/23/25. Staff would take R1's picture and keep a record of R1's information in case she ever left the building unattended, to be provided to anyone assisting to locate R1, created and initiated on 10/23/25 On 11/19/25, after the incident, R1's "Care Plan" was updated to include staff would attempt to keep the doors to R1's hallway closed. If she left the hallway, staff would closely monitor her and redirect her back to her hall, initiated on 11/16/25 and revised on 11/20/25. R1's "Behavior Note" dated 11/09/25 at 05:45 PM documented R1 was pacing and wandering and became agitated when staff attempted to redirect her. R1's "Behavior Note" dated 11/10/25 at 06:31 PM documented R1 wandered and paced throughout the facility with a steady gait (manner or style of walking) and became agitated when staff attempted to redirect her. R1's "Behavior Note" dated 11/11/25 at 05:10 PM documented R1 wandered and paced throughout the facility with a steady gait and became agitated when staff attempted to redirect her. R1's "Behavior Assessment Progress Note" dated 11/16/25 at 06:37 PM documented R1 wandered in the hallways and at other times into other residents' rooms. R1 was unable to stop wandering. R1's "Behavior Assessment Progress Note" dated 11/17/25 at 06:37 AM documented R1 displayed minimal wandering behaviors. Certified Medication Aide (CMA) J's unnotarized and undated witness statement documented on 11/16/25 at approximately 05:09 PM, R1 received her medications that accompanied the evening meal. The front door alarm sounded at the time of the evening meal. CMA J went to the front door and looked outside, then turned the alarm off, let a visitor out of the building, and then	F0689		

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F0689 SS = D	Continued from page 11 went back into the building to locate all the residents. CMA J documented she was then notified that R1 was found. Dietary EE's unnotarized and undated witness statement documented on 10/04/25, Dietary EE was outside and saw R1. Dietary EE assisted R1 back into the building. During an observation on 12/01/25 at 11:45 AM, R1 sat on the bed in her spouse's room with family in the room. She had an elopement bracelet on her left wrist. During an observation on 12/02/25 at 10:15 AM, R1 ambulated in the hallway holding hands with her spouse, with an elopement bracelet observed on her left wrist. During an interview on 12/03/25 at 08:57 AM, CMA J revealed R1 had wandering behaviors and was frequently redirected by her spouse. Staff sometimes intervened and redirected R1 with distractions or went on walks with R1 around the hallway where she lived. During an interview on 12/03/25 at 09:15 AM, Licensed Nurse (LN) G revealed R1 had wandering behaviors, and the wandering has improved since the intervention was implemented to keep the doors to the hallway where she lived closed. LN G said R1 often walked the hallway with her spouse, and her spouse was frequently able to redirect her away from other residents' rooms. During an interview on 12/02/25 at 04:45 PM, Administrative Staff A revealed that on the evening of 11/16/25 at approximately 05:22 PM, when the front door alarm sounded, staff responded appropriately, performed their duty, and met the facility's expectations. Administrative Staff A revealed the investigation included the review of security camera footage where R1 was observed following a visitor out the front door. Administrative Staff A reported the front doors had signage in English that warned visitors to not allow residents to leave the building. Administrative Staff A reported the visitor who allowed R1 to exit the building was Spanish-speaking only and therefore could not read the signage in English. Administrative Staff A reported that the signage on the front doors has been changed to include English and Spanish. Administrative Staff A also revealed that visitors, when they arrived in the facility, were being verbally educated and	F0689		

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F0689 SS = D	Continued from page 12 encouraged by staff to not allow anyone else out of the building when they exited. The facility's "Elopement" policy, dated 11/28/17, documented the facility would provide adequate supervision and devices to deter elopement.	F0689		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 33 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure medications were available for administration, as	F0755		

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F0755 SS = D	Continued from page 13 ordered by the physician, for Resident (R) 17. Findings included: - R17's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), psychotic disorder (any major mental disorder characterized by a gross impairment in reality perception), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). R17's 11/05/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R17's MDS documented she had minimal depression, hallucinations (perceptual experiences in the absence of real external sensory stimuli), and delusions (misconceptions or beliefs that are firmly held, contrary to reality) during the look-back period. The MDS documented no behaviors. The MDS documented R17 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders). R17's 11/12/25 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R17 was alert and oriented and able to make herself understood and understand others. She had diagnosis of dementia, psychotic disorder with hallucinations. R17 received fluvoxamine (an antidepressant) and risperdal (an antipsychotic). Nursing staff would monitor for effectiveness and possible adverse reactions. The resident had feelings of sadness more than half the days. She stated she would "be better off dead" and related these feelings to the hallucinations she was having. She would continue to be followed by a behavioral health provider. R17's "Care Plan" dated 02/01/24 instructed staff to monitor R17 for any side effects from antidepressant medications such as sedation, drowsiness, dry mouth, blurred vision, urinary retention (lack of ability to urinate and empty the bladder), tachycardia (rapid heartbeat greater than 100 beats per minute), muscle tremor, agitation, headache, skin rash, photosensitivity (sensitive to the light), and excess weight gain.	F0755		

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F0755 SS = D	Continued from page 14 R17's EMR documented an order for fluvoxamine 50 milligrams (mg) every evening for major depressive disorder dated 09/04/25. R17's "Medication Administration Record" (MAR) documented six missed doses of fluvoxamine 50 mg every evening, dated 11/14/25, 11/15/25, 11/16/25, 11/17/25, 11/18/25, and 11/19/25. R17's "Orders Administration Note" on 11/14/25 at 09:07 PM documented fluvoxamine 50 mg was not available. R17's "Orders Administration Note" dated 11/15/25 at 08:59 PM documented fluvoxamine 50 mg was not available. R17's "Orders Administration Note" dated 11/16/25 at 09:58 PM documented fluvoxamine 50 mg was not available. R17's "Orders Administration Note" dated 11/17/25 at 09:06 PM documented fluvoxamine 50 mg was not received. R17's "Orders Administration Note" dated 11/18/25 at 08:32 PM documented fluvoxamine 50 mg was not received. R17's "Orders Administration Note" dated 11/19/25 at 10:03 PM documented fluvoxamine 50 mg was not available. During an observation on 12/02/25 at 07:45 AM, R17 laid in her bed with eyes closed. During an interview on 12/03/25 at 09:18 AM, Certified Medication Aide (CMA) S reported that she would let the charge nurse know if a medication needed to be reordered when the medication was not available. CMA S reported that the nurse would order medications from the facility's pharmacy. During an interview on 12/03/25 at 09:42 AM, Licensed Nurse (LN) G reported the CMAs should let the nurse	F0755		

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F0755 SS = D	Continued from page 15 know when a medication was not available to administer and when a medication would need to be re-ordered from the facility's pharmacy. LN G reviewed R17's MAR and confirmed that R17 missed six doses of fluvoxamine in November 2025. During an interview on 12/03/25 at 10:29 AM, Administrative Nurse D reported she expected staff to order the medications and that all the residents should receive all their medications per the physician's orders. The facility's policy "Ordering and Receiving Medications from Provider Pharmacy" dated 2011 documented medications and related products are received from the provider pharmacy on a timely basis. Refill medications are ordered as follows: Five days in advance of need to assure an adequate supply is on hand. The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. The refill order is called in, faxed, or otherwise transmitted to the pharmacy. If orders are transmitted, a copy of the confirmation should be saved by the facility.	F0755		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §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	F0756		

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F0756 SS = D	Continued from page 16 report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents, with 12 residents sampled, and five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to act upon the pharmacist's monthly medication regimen review (MRR) for Resident (R) 17 and R8. Findings included: - R17's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), psychotic disorder (any major mental disorder characterized by a gross impairment in reality perception), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). R17's 11/05/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R17's MDS documented she had minimal depression, and she had hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality) during the look-back period. The MDS documented no behaviors. The MDS documented R17	F0756		

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F0756 SS = D	Continued from page 17 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders). R17's 11/12/25 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R17 was alert and oriented and able to make herself understood and understand others. She has diagnosis of dementia, psychotic disorder with hallucinations. R17 received fluvoxamine (an antidepressant) and risperdal (an antipsychotic). Nursing staff would monitor for effectiveness and possible adverse reactions. The resident had feelings of sadness more than half the days. She stated she would "be better off dead" and related these feelings to the hallucinations she was having. She would continue to be followed by a behavioral health provider. R17's "Care Plan" dated 02/01/24 instructed staff to monitor R17 for any side effects from antidepressant medications such as sedation, drowsiness, dry mouth, blurred vision, urinary retention (lack of ability to urinate and empty the bladder), tachycardia (rapid heartbeat greater than 100 beats per minute), muscle tremor, agitation, headache, skin rash, photosensitivity, and excess weight gain. R17's EMR documented an order for Neurontin (an anticonvulsant) 300 milligrams (mg) three times a day for chronic pain, dated 11/29/23. R17's EMR documented a discontinued order for Cymbalta 60 mg (an antidepressant, a class of medications used to treat mood disorders) once a day for major depressive disorder, discontinued date 07/24/25. R17's "Medication Regimen Review" (MRR) dated 2/17/2025 documented a periodic review was needed due to the risk of loss of coordination, respiratory suppression, irritability, suicidal thoughts, fatigue, behaviors, and depression. There is a serious increase in side effect risks if given with opioids. The MRR recommended changing Neurontin 300 mg three times a day to twice a day, or if no change, the pharmacist requested a note of benefit and continued medication.	F0756		

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F0756 SS = D	Continued from page 18 Review of R17's EMR lacked the actual report and response from the physician. R17's MRR dated 04/16/25 documented a periodic review was needed because antidepressants are associated with falls, fractures, psychosis, and sedation. The MRR recommended changing Cymbalta 60 mg every other day for five doses, then discontinue or change Cymbalta to 30 mg daily; if no change, the pharmacist requested a note of benefit and continued medication. Review of R17's EMR lacked the actual report and response from the physician. During an observation on 12/02/25 at 07:45 AM, R17 laid in her bed with eyes closed. During an interview on 12/03/25 09:40 AM, Licensed Nurse (LN) G reported that Administrative Nurse D would receive the MRR and then email or fax the reports to the required physicians. LN G reported she would only see the MRR after the physician had addressed the recommendations. During an interview on 12/03/25 at 10:21 AM, Administrative Nurse D reported she expected to receive all the MRR back completed and in a timely manner from the providers. Administrative Nurse D reported it was not acceptable to not have an MRR completed and returned. During an interview on 12/03/25 at 02:15 PM, Consultant Pharmacist HH reported he expected the provider to respond to recommendations within 30 days. Consultant HH reported he would revisit a recommendation in six months if it was not answered. The facility's policy "Medication Regimen Review (Monthly Report)", dated 2011, documented resident-specific MRR recommendations and findings are documented and acted upon by the facility and/or physician. If recommendations are rejected, the physician must provide a brief explanation (such as in a dated progress note). When the physician does not act upon or rejects the MRR report/recommendations, and there is potential for serious harm, the facility and/or consultant pharmacist should contact the Medical	F0756		

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F0756 SS = D	Continued from page 19 Director. - R8's Electronic Medical Record (EMR) revealed diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R8's 03/14/25 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of nine, which indicated moderately impaired cognition. R8's MDS recorded she received antidepressants (a class of medications used to treat mood disorders). R8's 03/28/25 " Psychotropic Drug Use Care Area Assessment" (CAA) documented R8 was usually able to make herself understood and understand others. She does have disorganized thinking but is easily redirected by staff. She is taking Cymbalta (an antidepressant). R8 reported feeling sad at times due to the father being gone, but denied any further intervention needed. Nursing would monitor medication for effectiveness and possible adverse reactions. R8's "Care Plan" instructed staff to monitor R8 for any side effects of the antidepressant medication, such as sedation, drowsiness, dry mouth, blurred vision, urinary retention (lack of ability to urinate and empty the bladder), tachycardia (rapid heartbeat greater than 100 beats per minute), muscle tremor, agitation, headache, skin rash, photosensitivity, and excess weight gain. R8's EMR documented an order for Cymbalta 60 milligrams (mg) daily for depression dated 08/19/23. R8's "Medication Regimen Review" (MRR) dated 04/16/25 documented a periodic review was needed because antidepressants are associated with falls, fractures, psychosis, and sedation. The MRR recommended changing Cymbalta 60 mg every other day for five doses, then discontinue; change Cymbalta to 30 mg daily or, if no change, the pharmacist requested a note of benefit and continued medication.	F0756		

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F0756 SS = D	Continued from page 20 Review of R8's EMR revealed the physician responded on 08/27/25, four months later, and documented no change because R8 was wheelchair bound, cooperative, and behaviors were minimal. During an observation on 12/01/25 at 8:15 AM, R8 sat in a wheelchair with a green lift sling under her. A blue colored right arm support was on her wheelchair, and her left hand was clenched shut with no device or carrot observed in her hand. During an interview on 12/03/25 at 09:40 AM, Licensed Nurse (LN) G reported that Administrative Nurse D would receive the MRR and then email or fax the reports to the required physicians. LN G reported she would only see the MRR after the physician had addressed the recommendations. During an interview on 12/03/25 at 10:21 AM, Administrative Nurse D reported she expected to receive all the MRR back completed and in a timely manner from the providers. Administrative Nurse D reported it was not acceptable to not have an MRR completed and returned. During an interview on 12/03/25 at 02:15 PM, Consultant Pharmacist HH reported he expected the provider to respond to recommendations within 30 days. Consultant HH reported he would revisit a recommendation in six months if it is not answered. The facility's policy "Medication Regimen Review (Monthly Report)" dated 2011 documented resident-specific MRR recommendations and findings are documented and acted upon by the facility and/or physician. If recommendations are rejected, the physician must provide a brief explanation (such as in a dated progress note). When the physician does not act upon or rejects the MRR report/recommendations, and there is potential for serious harm, the facility and/or consultant pharmacist should contact the Medical Director.	F0756		
F0759 SS = SQC-F	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F0759		

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F0759 SS = SQC-F	Continued from page 21 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 33 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent when 25 medication administration opportunities were observed with two medication errors identified for Resident (R) 10. This resulted in a medication error rate of eight percent. Findings included: - R10's "Physician Orders", date ordered 11/21/24, recorded an order for budesonide suspension (an inhaled medication) 0.25 milligrams (mg)/ 2 milliliters (ml) vial, inhale orally via nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) two times a day related to interstitial pulmonary disease (a disorder that causes progressive scarring of lung tissue) after breathing treatment rinse mouth after use. Must be given separately. Do not mix with other nebulizer solutions. R10's "Physician Orders" recorded an order for Metamucil fiber (a laxative and fiber supplement), administer 2 tablespoons (Tbsp) by mouth, one time a day for bowel management, mix with eight ounces of fluid, date ordered 09/26/24. During an observation on 12/02/25 at 08:29 AM, Licensed Nurse (LN) G administered R10s budesonide suspension via nebulizer when the breathing treatment was completed. LN G removed the nebulizer mask and rinsed the equipment for another breathing treatment. LN G failed to offer R10 to rinse her mouth after use of the Budesonide suspension. During an interview on 12/02/25 at 08:50 AM, LN G reported she should have offered R10 a rinse of water after she removed the first breathing treatment. During an observation on 12/02/25 at 09:15 AM, Certified Medication Aide (CMA) R administered R10's Metamucil fiber. CMAR pulled a stock bottle of fiber laxative from the med cart, poured some of the	F0759		

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F0759 SS = SQC-F	Continued from page 22 medication into the cap of the bottle, and then poured that into a cup. CMA R was requested to pour the medication from the cup into a plastic 30 ml medicine cup to verify the amount poured. CMA R poured the medicine into the measuring medication cup. Observed 10 ml of fiber laxative in the cup and reported that it was what she administered every day to R10, and reported that it was 2 tablespoons when she was asked what the dose was. CMA R then administered all of R10's medications. During an interview on 12/02/2025 11:47 AM, LN G reported that she expected the CMAs to provide the correct dose of medication and reported that R10 should have been administered the correct dose. During an interview on 12/02/25 at 11:51 AM, Administrative Nurse D reported she expected the LN's and CMAs to administer all medications correctly as per physician orders. The facility's policy "Medication Administration General Guidelines", dated 2011, documented the medications are administered in accordance with written orders of the attending physician. Read the medication label and compare it with the medication administration record before pouring.	F0759		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 33 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to prevent a significant medication error when the facility did not administer Resident (R)17's antidepressant (a class of medications used to treat mood disorders) medication for six consecutive and never notified the physician. Findings included: - R17's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), psychotic disorder (any major mental disorder characterized by a gross impairment in reality	F0760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN PRAIRIE SENIOR LIVING LLC	510 E SAN JACINTO AVENUE , ULYSSES, Kansas, 67880

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F0760 SS = D	Continued from page 23 perception), and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). R17's 11/05/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R17's MDS documented she had minimal depression, and she had hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality) during the look-back period. The MDS documented no behaviors. The MDS documented R17 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant. R17's 11/12/25 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R17 was alert and oriented and able to make herself understood and understand others. She has diagnosis of dementia, psychotic disorder with hallucinations. R17 received fluvoxamine (an antidepressant) and risperdal (an antipsychotic). Nursing staff would monitor for effectiveness and possible adverse reactions. The resident had feelings of sadness more than half the days. She stated she would "be better off dead" and related these feelings to the hallucinations she was having. She would continue to be followed by a behavioral health provider. R17's "Care Plan" dated 02/01/24 instructed staff to monitor R17 for any side effects from antidepressant medications such as sedation, drowsiness, dry mouth, blurred vision, urinary retention (lack of ability to urinate and empty the bladder), tachycardia (rapid heartbeat greater than 100 beats per minute), muscle tremor, agitation, headache, skin rash, photosensitivity, and excess weight gain. R17's EMR documented an order for fluvoxamine 50 milligrams (mg) every evening for major depressive disorder dated 09/04/25. R17's "Medication Administration Record" (MAR) documented six missed doses of fluvoxamine 50 mg every evening, dated 11/14/25, 11/15/25, 11/16/25, 11/17/25, 11/18/25, and 11/19/25.	F0760		

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F0760 SS = D	Continued from page 24 R17's "Orders Administration Note" on 11/14/25 at 09:07 PM documented fluvoxamine 50 mg as not available. R17's "Orders Administration Note" dated 11/15/25 at 08:59 PM documented fluvoxamine 50 mg as not available. R17's "Orders Administration Note" dated 11/16/25 at 09:58 PM documented fluvoxamine 50 mg as not available. R17's "Orders Administration Note" dated 11/17/25 at 09:06 PM documented fluvoxamine 50 mg as not received. R17's "Orders Administration Note" dated 11/18/25 at 08:32 PM documented fluvoxamine 50 mg as not received. R17's "Orders Administration Note" dated 11/19/25 at 10:03 PM documented fluvoxamine 50 mg as not available. R17's "Behavioral Health Provider Note" dated 11/19/25 at 03:30 PM, documented nursing staff confirmed R17 had been taking all her medications as prescribed. R17's EMR lacked evidence the physician was notified during the six days the resident did not receive the medication as ordered. During an observation on 12/02/25 at 07:45 AM, R17 laid in her bed with eyes closed. During an interview on 12/03/25 at 09:42 AM, Licensed Nurse (LN) G reported the CMAs should let the nurse know when a medication was not available to administer and when a medication would need to be re-ordered from the facility's pharmacy. LN G reviewed the MAR and confirmed that R17 missed six doses of fluvoxamine in November 2025. LN G reported the provider should have been notified and confirmed that the provider had not been notified of the missed medication. During an interview on 12/03/25 at 10:29 AM, Administrative Nurse D reported she expected staff to order the medications and that all the residents should	F0760		

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F0760 SS = D	Continued from page 25 receive all their medication per the physician's orders. Administrative Nurse D reported she expected the LNs to notify the provider when a medication was not administered. During an interview on 12/03/25 at 10:43 AM, Consultant Staff GG, the behavioral health provider, reported that she was not notified that R17 missed the six doses of fluvoxamine in November 2025. Consultant Staff GG reviewed the MAR on her computer and reported that she observed staff's initials for the days of the missed medication and reported that she had not noticed the number nine above the initial, which indicated to see the progress note. Consultant Staff GG expected the staff to update her on any missed doses and reported the residents should not be missing medications, and said she wondered how this happened. The facility's policy "Medication Error and Drug Reactions", dated 11/28/2017, documented all medication errors and drug reactions must be immediately reported to the physician, Director of Nursing, and the resident and/or their representative. All medication errors will be reviewed by the Quality Assurance Committee.	F0760		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812		

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F0812 SS = F	Continued from page 26 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents, and one main kitchen. Based on observation, record review and interview the facility failed to prepare and serve food under sanitary conditions to prevent potential for food borne bacteria. Finding included: - On 12/01/25 at 07:35 AM, the initial tour of the kitchen revealed a 50-pound bag of rice unsealed and sitting on the bottom shelf in dry storage. The following items did not have an open date: food coloring, a gallon of corn syrup, a bottle of vanilla, a gallon of milk, and a gallon of thousand island dressing. On 12/01/25 at 07:35 AM, observation of the refrigerator revealed a bag of sliced cheese unsealed, and a mixed salad with no date or label. There were food items with no dates, including a container of salsa and a bag of cauliflower. On 12/01/25 at 07:35 AM, observation of the freezer revealed a box of rolls on the floor and a bag of tamales for an employee. On 12/02/25 at 09:43 AM, Dietary Aide DD used the dishwasher. He reported he was not sure how to check the temperature and did not know about any temperature log. Observation revealed the temperature gauge showed 80 degrees Fahrenheit. The ice machine vent leaned on the floor over a dirty hole. On 12/03/25 at 10:05 AM, an observation in the kitchen revealed several stained and scratched cutting boards. A muffin tin had baked-on brown crusted areas. Further observation revealed pans with dents, scratches, and hard black substances on the cooking area surface. A large cooking pot had several dents, and the plastic lid covers were cracked and broken. On 12/03/25 at 12:25 PM, Administrative Staff A reported everything should be labeled with a date and sealed, and all kitchen equipment should be in good	F0812		

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F0812 SS = F	Continued from page 27 working order and clean. Administrative Staff A said the dishwasher temperature not being checked was a concern. The policy "Dishwashing: Machine" was revised on 4/27/20. The dining service staff shall maintain the operation of the dishwashing machine according to established procedure and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in preparation and service of food. Appropriate documentation will be kept. The policy "Food Storage", revised 04/06/20, documents the food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at an appropriate temperature and using appropriate methods to ensure the highest level of food safety. Label all food items with the name of the food and the date it was opened or prepared.	F0812		
F0880 SS = D	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	F0880		

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F0880 SS = D	Continued from page 28 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. (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 reported a census of 33 residents with 12 residents sampled. Based on observation, interview and	F0880		

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F0880 SS = D	Continued from page 29 record review the facility failed to maintain an effective infection control practices for three residents, Resident (R) 7, R4, nd R2 related to incorrect use of personal protective equipment (PPE – gowns, face shields and/or eyeglasses/goggles, and gloves), lack of appropriate hand hygiene and inadequate enhanced barrier precautions (EBP – an infection control intervention designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) during high contact cares. The facility further failed to initiate contact precautions while awaiting culture results for clostridium difficile (C-diff- contagious bacterial infection characterized by foul-smelling frequent loose bowel movements). Findings included: - Review of R7's Electronic Health Record (EHR) under the "Orders" tab revealed a one-time order for a stool culture that included screening for c-diff, dated 11/20/25. Review of the scanned documents in R7's EHR revealed no results for the stool culture that included screening for c-diff. During an observation on 12/02/25 at 09:21 AM, Certified Nurse Aide (CNA) L and CNA K performed incontinence care for R7. Both CNA staff entered R7's room and donned gloves and a plastic gown without performing hand hygiene or putting the cuff of the gloves over the sleeves of the gown. They removed R7's blankets and lowered the bed to a flat position. They removed R7's brief, and CNA K cleaned R7's left and right inguinal folds (the groin crease where the leg joins the trunk), then cleaned stool off R7's genitals without obtaining a new wipe or folding to a clean portion of the wipe. CNA K pushed the soiled wipe between R7's legs below his genitals. CNA K then obtained a new wipe and further cleaned stool off R7's genitals and pushed the soiled wipe between his legs below his genitals. CNA L rolled R7 to his left side, and CNA K cleaned R7's buttocks and anus. CNA K removed her gloves, performed hand hygiene, donned new gloves, then removed the soiled wipes from between R7's legs but did not change her gloves or perform hand hygiene before continuing to the clean phase of incontinence care. CNA K placed a partially rolled up mattress protector pad and brief under R7, and both CNAs rolled the resident to his right and then onto his back for proper brief and mattress protector placement. CNA K	F0880		

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F0880 SS = D	Continued from page 30 cleaned R7's genitals wearing the same soiled gloves. CNA K then doffed the gloves, performed hand hygiene, and donned new gloves. CNA L doffed the PPE without performing hand hygiene and left the room to retrieve supplies for a full-body mechanical lift. When CNA L returned to the room, she donned gloves without performing hand hygiene and did not put on a gown. Both CNA staff positioned the sling for the mechanical lift under the resident and assisted R7 into his wheelchair. CNA L cleaned the handles of the mechanical lift and the crossbar for the mechanical lift with a disinfectant wipe. Both CNA staff removed their remaining PPE without performing hand hygiene and exited the room with the lift. During an interview on 12/02/25 at 09:49 AM with CNA K and CNA L, both CNA staff confirmed the observation findings and stated they should have performed hand hygiene upon entering R7's room prior to putting on any PPE. CNA K stated she should have changed gloves and performed hand hygiene when she removed the soiled wipes from between R7's legs and after cleaning R7's genitals before continuing with placement of the clean brief and mattress protector pad. CNA L revealed she should have performed hand hygiene after removing the PPE when she left the room to retrieve the mechanical lift. During an interview on 12/03/25 at 09:15 AM, Licensed Nurse (LN) G revealed prior to incontinence care, staff should perform hand hygiene before putting on any applicable PPE. LN G stated during incontinence care, the facility's procedure for cleaning residents allows the staff to wipe the resident, then fold the wipe once to expose a clean area of the wipe, then discard the wipe and retrieve a new wipe for additional cleaning if needed. LN G stated that every time gloves were removed, hand hygiene should be performed before putting on new gloves. LN G stated for EBP, the cuff of the gloves should be placed over the end of the sleeves on the gown. During an interview on 12/03/25 at 09:30 AM, Administrative Nurse D revealed staff were allowed to fold the wipe after use and utilize a clean portion of the wipe for a second pass if needed, and then the wipe should be discarded and a new wipe obtained if additional cleaning was required or necessary. During an interview on 12/03/25 at 01:20 PM,	F0880		

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F0880 SS = D	Continued from page 31 Administrative Nurse D confirmed the order for R7's stool to be cultured for c-diff and that the results had not been received from the laboratory. Administrative Nurse D revealed R7 should have been placed under contact isolation precautions instead of EBP when the provider ordered a c-diff culture. Administrative Nurse D stated staff should perform hand hygiene before putting on any PPE, when changing gloves during cares, and immediately following the removal of PPE before leaving the residents' rooms. Administrative Nurse D said that when putting on PPE for EBP, staff should put the gown on first, then the gloves, and tuck the sleeves of the gown inside the cuff of the gloves. The facility's "Enhanced Barrier Precautions [sic] (EBP)" policy, dated 04/01/25, documented EBP employed targeted gown and glove use during high-contact resident care activities. The policy did not outline the order in which the PPE would be applied or removed by staff. The facility's "Hand Hygiene" policy, dated 11/28/17, documented hands would be cleaned with soap and water after care for a resident with known or suspected c-diff infection. The policy documented hands would be cleaned with an alcohol-based hand-rub (ABHR) before and after contact with a resident and after removing PPE. If hands were visibly soiled, hands should be washed with soap and water. The facility's "Isolation" policy, dated 04/16/20, documented isolation precautions would be utilized when there is a reason to believe a resident has an infection or communicable disease.	F0880		
F0921 SS = C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 33 residents. Based on observation, record review and interviews the facility failed to promote a safe, sanitary environment on the ceilings throughout the residents rooms as well	F0921		

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F0921 SS = C	Continued from page 32 as the dining room and activity room. Findings included: - On 12/2/25 at 01:03 PM, observations during the environment tour with Maintenance Staff U revealed 31 of the 33 residents had missing ceiling tiles in their room next to the ceiling heat vent. Ceiling tiles in hall 200 and hall 300 near the dining room and activity room were discolored. On 12/2/25 at 1:03 PM, the dishwasher temperature was at 80 degrees Fahrenheit (F); the dishwasher is a low-temperature sanitation. Maintenance Staff U reported the plumber came into the facility while he had been gone to work on the dishwasher and connected the plumbing incorrectly to the cold piping. Maintenance Staff U fixed the plumbing and retested the temperature, which then measured 127 degrees F. On 12/02//24 at 01:03 PM, Maintenance Staff U said the ceiling tiles in the resident's room were not in place because the heating and cooling system was old and caused the ceiling tiles to get wet, causing them to be discolored and fall from the suspended ceiling. He said the facility removed the ceiling tiles to visualize the drips of water so they would know if there was a concern to address. The facility did not provide a policy.	F0921		