STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSVILLE MANOR	**304 W 7TH ST , WELLSVILLE, Kansas, 66092**

(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 A recertification survey was conducted at WELLSVILLE MANOR on 05/19/26 – 05/21/26 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility census on the first day of the survey was 49. The sample size included 13 residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.	F0801		

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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F0801 SS = F	Continued from page 1 (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.	F0801		

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F0801 SS = F	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide the services of a full-time Certified Dietary Manager (CDM) for the residents who resided in the facility and received their meals from the kitchen. Findings included: - On 05/20/26 at 11:00 AM, Dietary Staff BB verified she was the Certified Dietary Manager (CDM) for the two facility kitchens but continued to work at another facility as well. During an interview on 05/21/26 at 09:35 AM, Administrative Staff A stated there should be a full-time CDM on site, and this was the expected transition for Dietary Staff BB. Administrative Staff A verified there should be a qualified dietician or other clinically qualified nutrition professional working full-time in the facility, to oversee the kitchen staff and dietary needs of the residents. During an interview on 05/21/26 at 11:05 AM, Consultant GG verified she was overseeing seven facilities kitchens and currently visits this facility on Fridays, then verified that neither she nor the CDM are working over 35 hours a week at the current facility.	F0801		
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.	F0812		

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F0812 SS = F	Continued from page 3 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure effective sanitizing of dishes when the sanitizer did not reach 120 degrees Fahrenheit, in one of the facility's two kitchens. Findings included: - During an observation on 05/20/26 at 12:15 PM, Dietary Staff EE ran a cycle of glassware through the sanitizer, in the secondary kitchen, and verified the temperature was 111 degrees Fahrenheit (F). During an interview on 05/20/26 at 12:30 PM, Maintenance Staff U confirmed the temperature on the sanitizer should be 120 degrees F. On 05/20/26 at 03:00 PM, Maintenance Staff U stated the temperature on the sanitizer was adjusted to 120 degrees Fahrenheit. The facility's undated Dietary Services Leadership & Shared CDM Policy stated residents are to receive safe, sanitary, and nutritionally adequate meals in accordance with physician orders, resident preferences and regulatory requirements.	F0812		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880		

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F0880 SS = F	Continued from page 4 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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.	F0880		

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F0880 SS = F	Continued from page 5 §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: Based on observation, interview, and record review, the facility failed to implement adequate infection control practices when staff failed to perform hand hygiene and failed to sanitize shared equipment. Findings included: - On 05/20/2026 at 01:25 PM, an observation revealed Certified Nurse Aide (CNA) P and CNA N used a Hoyer lift (full body mechanical lift) for Resident (R) 35 who was on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) and transferred the resident from the wheelchair to the bed to change the resident's soiled brief. CNA P and CNA N washed their hands and applied personal protective equipment (PPE- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses before transferring and changing resident). CNA P and CNA N removed the soiled brief and applied a clean brief without changing gloves and performing hand hygiene. The two CNA staff then removed their PPE and placed it in the trash. On 05/20/2026 at 01:35 PM, an observation revealed CNA P and CNA N removed the Hoyer lift from R35's room and took it to R29's room across the hall without cleaning the lift. CNA P and CNA N used the unsanitary Hoyer lift to transfer R29 to the bed from the resident's wheelchair. On 05/20/2026 at 01:50 PM, an observation revealed CNA N removed the Hoyer lift from R29's room and placed it in the clean storage area with the other Hoyer lift without cleaning it. During an interview on 05/20/2026 at 02:04 PM, CNA P stated that dayshift does not clean the Hoyer lifts after resident use and only night shift was responsible for cleaning the equipment. CNA P indicated the Hoyer would be cleaned later that night. During an interview on 05/20/2026 at 02:10 PM,	F0880		

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F0880 SS = F	Continued from page 6 Licensed Nurse (LN) G stated that staff was supposed to clean the Hoyer lift after each resident use, and the night shift staff was responsible for deep cleaning the Hoyer lift. LN G went down to the clean storage area and cleaned the Hoyer lifts. During an interview on 05/20/2026 at 02:17 PM, Administrative Nurse E stated that the Hoyer lift was to be cleaned after each resident use and was to be deep cleaned by the night shift staff. Administrative Nurse E said the day shift staff had been educated on cleaning the Hoyer lift after each resident use. The facility's undated policy "Equipment Cleaning Disinfection Policy" documented that resident care equipment shall be cleaned and disinfected between resident use and whenever visibly soiled, contaminated, or as indicated by manufacturer instructions, facility infection prevention protocols, or applicable regulatory requirements. The facility's undated policy "Enhanced Barrier Precautions" documented the facility followed recommendations and guidance from the Centers for Disease Control to keep all residents safe from Healthcare Acquired Infections (infections that residents acquire while receiving medical treatment in a healthcare facility).	F0880		
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.	F0552		

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F0552 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to inform Resident (R) 5 or her representative about the risk and benefits of taking an antidepressant (a class of medications used to treat mood disorders). Findings included: - R5's Electronic Medical Record (EMR) revealed the following diagnoses: major depressive disorder (major mood disorder that causes persistent feelings of sadness). R5's 06/10/25 “Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R5 took a diuretic (a medication to promote the formation and excretion of urine), opioid (a class of controlled drugs used to treat pain), hypoglycemic (a type of medication to treat high blood glucose levels), and an anticonvulsant. R5’s “Falls Care Area Assessment” (CAA) documented R5 received pain medications and diabetic medications. R5’s “Psychotropic Drug Use CAA” was not triggered. R5’s "Care Plan" documented R5 took an antidepressant for a diagnosis of major depressive disorder to improve functioning and reduce symptoms on 03/16/26. R5’s “Physician’s Orders” documented an order for sertraline 50 milligrams mg every evening, ordered on 05/29/25. R5’s EMR had a “Consent for Use of Psychotropic Medication” dated 03/16/26. The uncompleted assessment documented R5 took sertraline 50mg for depression. The consent was unsigned. R5’s EMR showed no indication that R5 or the representative was notified of the medication including the risk verses benefits or potential side effects of the medication. On 05/21/26 at 08:26 AM, R5 sat in her recliner watching television. R5 appeared relaxed and comfortable. On 05/21/26 at 10:14 AM, Administrative Nurse F	F0552		

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F0552 SS = D	Continued from page 8 stated Administrative Nuse D did the consents for medication. On 05/21/26 at 10:28 AM, Administrative Nurse D stated that they realized in March that they had not done the consents on any psychotropic medications. They began to do them at that time. Administrative Nurse D verified that the resident or representative did not consent to the medication. It must have been skipped over. The facility policy for "Medication Management, Consents, and Monitoring," undated, documented prior to initiating psychotropic medications, the facility shall inform the resident and/or legal representative of medication name and purpose, risk and benefits, potential side effects, alternative treatment options, and the right to refuse treatment. The facility will maintain a signed consent in the medical record.	F0552		
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.	F0605		

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F0605 SS = D	Continued from page 9 §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific	F0605		

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F0605 SS = D	Continued from page 10 condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to accurately assess and monitor a psychotropic medication for Resident (R) 27, who received Ambien (a psychotropic medication used to induce sleep) nightly. Findings included: - R27's Electronic Medical Record (EMR) revealed the following diagnoses: insomnia (inability to sleep) and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R27's 09/08/25 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R27 took an antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), and opioid (a class of controlled drugs used to treat pain). The MDS did	F0605		

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F0605 SS = D	Continued from page 11 not accurately document that R27 took a hypnotic (a class of medications used to induce sleep). R27's 09/08/25 “Psychotropic Drug Use Care Area Assessment” (CAA) documented R27 took pain medication which managed her pain well but lacked documentation of the hypnotic or diagnosis of insomnia. R27’s "Care Plan" documented R27 took Ambien, which had a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). It directed staff to monitor pain, sleep patterns, and respirations. Do not give more than seven to ten days consecutively on 03/14/26. R27’s “Physician’s Orders” documented an order for zolpidem (Ambien) 5mg for insomnia every night, start dated 04/29/26. R27’s EMR lacked evidence of monitoring for side effects and effectiveness for the ongoing use of the Ambien. On 05/19/26 10:06 AM, R27 reclined in her recliner with her feet up. R27 requested that the facility switch out her bed for the recliner. R27 stated all she does all day was just lay here. R27 reported that she liked staying in her room. On 05/21/26 8:59 AM Licensed Nurse (LN) G stated that how the staff monitored the effectiveness of a psychotropic medication is a reminder to document the behaviors and adverse reactions originating on the care plan and it goes to the orders, where the nurse saw it and documented on the medications in a nurse’s note. Different medications have different frequencies for documentation. R5 had a reminder to document on the sertraline every six weeks. R27 did not have a reminder to monitor the zolpidem, and the nurses had not been monitoring this hypnotic medication for sleep. On 05/21/26 at 10:14 AM, Administrative Nurse F noted R27’s Ambien should have been added to the care plan should have been documented on the care plan at admission so staff could document on the effectiveness of the medication. On 05/21/26 at 10:28 AM, Administrative Nurse D stated she fixed it so the zolpidem was now showing up on the care plan so the nurse would document it. The facility policy "Medication Management, Consents, and Monitoring," undated, documented	F0605		

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WELLSVILLE MANOR	**304 W 7TH ST , WELLSVILLE, Kansas, 66092**

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F0605 SS = D	Continued from page 12 residents have the right to be free from unnecessary medications. The facility will ensure medications are used only when clinically indicated, monitored for effectiveness and adverse consequences, and supported by appropriate documentation.	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge	F0628		

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F0628 SS = D	Continued from page 13 in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F0628		

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F0628 SS = D	Continued from page 14 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and	F0628		

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F0628 SS = D	Continued from page 15 resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide Resident (R) 2, and R54 a written notification of transfer to the resident and/or his representative as soon as practicable and failed to send a copy of that notification to the ombudsman. The facility also failed to provide R2 or the representative with the bed-hold upon discharge to the hospital. Findings included:	F0628		

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F0628 SS = D	Continued from page 16 1. R2's Electronic Medical Record (EMR) revealed a diagnosis of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) and urinary tract infection (UTI-an infection in any part of the urinary system). R2's "Minimum Data Set" (MDS) tab documented a "Discharge MDS" on 11/20/25, 01/23/26, 03/14/26, and 04/26/26. R2's "Nurse's Note," dated 11/21/25 at 01:50 AM, documented R2 returned to the facility after having the nephrostomy tubes changed, at 09:10 PM, R2 had a temperature of 102 Fahrenheit (F), and was sweating and had low back pain. The doctor was notified and advised staff that R2 likely required evaluation at the hospital due to similarities to previous UTI/sepsis episode. R2 was sent out to the hospital. R2's "Nurse's Note," dated 01/23/26 at 05:10 PM, documented R2 had red colored urine and a fever. The doctor was notified and gave the order to send R2 to the emergency room for evaluation. R2's "Nurse's Note," dated 03/14/26 at 04:56 PM, documented R2 had lower back pain and reported that one of her nephrostomy tubes felt like it was being pulled. Assessment of the right nephrostomy tube site revealed the nephrostomy dressing was soiled with what appeared to be dried mucus. The opening where the tube enters the skin also appeared larger than expected. Sutures were present and intact. A small amount of blood and sediment was observed in the right outermost tube and bag. The dressings were changed, and the doctor was notified and recommended applying mupirocin ointment to insertion site and monitoring closely. R2's "Nurse's Note," dated 03/14/26 at 05:57 PM, documented R2 had a fever of 101.3 F and pain to her right outermost nephrostomy tube. The doctor was notified and provided an order to send R2 to the hospital. R2's "Nurse's Note," dated 04/26/26 at 08:54 PM, documented R2 continued to have a temperature of 101.2 F an hour after she received Tylenol. The doctor was notified and gave the order to send R2 to the hospital if R2 worsened. R2's "Nurse's Note," dated 04/26/26 at 09:55 PM, documented R2's temperature was now 102.9 and the nurse sent her to the hospital.	F0628		

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F0628 SS = D	Continued from page 17 R2's EMR lacked documentation that the bed hold was provided to the resident or the representative. The EMR also lacked documentation of a written notification to the residents and/or the representative, which explained the reason for the transfer to the hospital, or that the ombudsman was notified of the transfer. The facility was unable to provide the evidence upon request. 2. R54's "Nurse's Note," dated 03/26/26 at 01:39 PM, documented R54 had complaints of chest pain that radiated to his jaw and arms. The doctor was notified and gave the order to have him evaluated at the emergency room. R54 was transported by ambulance. R54's EMR lacked documentation of a written notification to the residents and/or the representative, which explained the reason for the transfer to the hospital, or that the ombudsman was notified of the transfer. The facility was unable to provide the evidence upon request. During an interview on 05/19/26 at 01:50 PM, Administrative Nurse E stated that, to her knowledge, the ombudsman was not notified of the discharges or transfers of the LTC residents. During an interview on 05/20/2026 11:30 AM, Social Service X stated she was unaware of the regulation to provide a bed hold to the resident or representative at the time of transfer. Social Service X was also unaware of the regulation to notify the residents and/or the representative in writing of the reason for the transfer and appeal policy and notify the ombudsman of transfers. During an interview on 05/20/26 at 08:54 AM, Administrative Staff A said the SS X had been responsible for providing bed holds and transfer/discharge notification. She also said that the ombudsman had not been notified in writing of transfers and discharges, but the facility contacted the ombudsman on 05/19/26 and have implemented a policy to contact the ombudsman in writing of all transfers and discharges. The facility's policy "Ombudsman Notification and Transfer/Discharge Policy" documented the facility shall comply with all applicable federal and Kansas requirements regarding resident transfer and discharge notification, including to the Kansas Long-Term Care Ombudsman Program.	F0628		

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F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F0636		

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F0636 SS = D	Continued from page 19 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to accurately assess Resident (R) 5 and R27. Findings included: 1. R5's Electronic Medical Record (EMR) revealed the following diagnoses: major depressive disorder (major mood disorder that causes persistent feelings of sadness). R5's 06/10/25 “Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R5 took a diuretic (a medication to promote the formation and excretion of urine), opioid (a class of controlled drugs used to treat pain), hypoglycemic (a type of medication to treat high blood glucose levels), and an anticonvulsant. The “MDS” did not accurately document that R5 took an antidepressant (a class of medications used to treat mood disorders). R5’s 06/10/25 “Falls Care Area Assessment” (CAA) documented R5 received pain medications and diabetic medications. R5’s 06/10/25 “Psychotropic Drug Use CAA” was not triggered due to not being accurately assessed on the MDS.	F0636		

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F0636 SS = D	Continued from page 20 R5's "Care Plan" documented R5 took an antidepressant for a diagnosis of major depressive disorder to improve functioning and reduce symptoms on 03/16/26. R5's June 2025 "Electronic Medication Administration Record" (EMAR) documented R5 took sertraline 50 milligrams (mg) on 06/04/25, 06/05/25, 06/06/25, 06/07/25, 06/08/25, 06/09/25, and 06/10/25. R5's "Physician's Orders" documented an order for sertraline 50 milligrams mg every evening, ordered on 05/29/25. R5's June 2025 "Electronic Medication Administration Record" (EMAR) documented R5 took sertraline 50 milligrams(mg) on 06/04/25, 06/05/25, 06/06/25, 06/07/25, 06/08/25, 06/09/25, and 06/10/25. On 05/21/26 at 08:26 AM, R5 sat in her recliner watching television. R5 appeared relaxed and comfortable. 2. R27's Electronic Medical Record (EMR) revealed the following diagnoses: insomnia (inability to sleep) and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R27's 09/08/25 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R27 took an antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), and opioid (a class of controlled drugs used to treat pain). The "MDS" did not accurately document that R27 took a hypnotic (a class of medications used to induce sleep). R27's 09/08/25 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R27 took pain medication that managed her pain well but lacked documentation of the hypnotic or diagnosis of insomnia. R27's "Care Plan" documented R27 took Ambien, which had a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). It directed staff to monitor pain, sleep patterns, and respirations. Do not give more than seven to ten days consecutively on 03/14/26.	F0636		

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F0636 SS = D	Continued from page 21 R27's "Care Plan" was not updated with the Psychotropic Use care plan for the nurse to document behaviors and side effects. R27's "Physician's Orders" documented an order for zolpidem 10 mg every night, ordered on 09/02/25. R27's September 2025 "Electronic Medication Administration Record" (EMAR) documented R5 took zolpidem 10 mg on 09/02/25, 09/03/25, 09/04/25, 09/05/25, 09/06/25, 09/07/25, and 09/08/25 On 05/19/26 at 10:06 AM, R27 reclined in her recliner with her feet up. R27 requested that the facility switch out her bed for the recliner. R27 stated all she does all day is lay here. R27 reported that she liked staying in her room. On 05/21/26 at 10:14 AM, Administrative Nurse F stated that, according to the EMAR, R5 had taken the antidepressant during the lookback period and should have been documented on the MDS. Administrative Nurse F verified understanding that since it was not documented on the MDS, it was not documented on the CAA, and on the care plan at admission. Administrative Nurse F verified that, according to the EMAR, R27 had taken the hypnotic medication during the lookback period and it should have been documented on the MDS. On 05/21/26 at 10:28 AM, Administrative Nurse D stated that she expected the MDS to accurately represent the residents. The facility policy for "MDS Accuracy Policy", undated, documented the purpose of the policy was to ensure MDS assessments are completed accurately, in a timely manner, and in accordance with regulations.	F0636		
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	F0689		

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F0689 SS = D	Continued from page 22 accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to identify and implement resident-centered interventions and monitor effectiveness of interventions to prevent falls for Resident (R) 3 who was at high risk for falls. Findings included: - R3's Electronic Health Record (EHR) documented diagnoses of pneumonitis (an infection in the lungs due to inhalation of food and vomit), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), polyosteoarthritis (degenerative changes to many joints characterized by swelling and pain), encephalopathy (a broad term for any brain disease that alters brain function or structure), dementia (a progressive mental disorder characterized by failing memory and confusion), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), urinary tract infection (UTI-an infection in any part of the urinary system), overactive bladder (a sudden, uncontrollable urge to urinate that is difficult to postpone), and diarrhea. R3's "Annual Minimum Data Set (MDS)," dated 03/19/2026, documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. R3 required a wheelchair for mobility. The MDS documented that R3 was set up for clean-up assistance for eating and was dependent on transfers and substantial to maximal assistance for most of her other activities of daily living (ADL). R3's "Care Plan," dated 03/17/25 documented she was at risk for falls due to weakness, impaired balance, incontinence and disease conditions. The care plan directed staff to place the bed in the lowest position as a fall intervention for a fall on 05/03/25. R3's "Care Plan," directed staff to ensure bedside commode is in the bathroom with the curtain pulled as a 05/18/26 fall intervention. R3's "Care Plan," documented frequent visual checks between 09:00 PM and 12:00 AM for the fall date of 12/15/25.	F0689		

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F0689 SS = D	Continued from page 23 R3's "Re-admission Fall Risk Evaluation," dated 02/20/26, documented that she had a history of one or more falls within the previous 6 months and documented she is not a low fall risk. R3's "Annual Fall Risk Evaluation," dated 03/14/26, documented a history of one or more falls within the previous 6 months and documented she is not a low fall risk. R3's "Safety Event-Copy of Fall Assessment and Root Cause Analysis", dated 05/18/26, documented an unwitnessed fall with injury, and that R3 was reaching for something and slid or fell from her wheelchair. R3's EHR "Progress Note," dated 03/07/26 and timed at 03:38 PM, documented by a note by Licensed Nurse (LN) H, which listed the root cause of the fall was R3 attempted to transfer to the commode and did not use her call light. LN H further documented that Certified Nursing Aide (CNA) N had discovered R3 sitting on the floor in front of her wheelchair with one hand on the grab bar right outside of her bathroom and that R3 stated she was trying to use the commode. LN H documented that R3 did not use her call light and that neurological assessments were initiated because R3 had a BIMs score of five that indicated severe cognitive impairment. Observed on 05/13/26 at 02:36 PM, R27 sat in her wheelchair in the common area television room and played dominoes with staff and another resident. Observed on 05/20/26 at 08:05 AM, R3 lay in bed with her eyes closed on a scoop mattress. The bed was raised approximately three to four feet from the floor and was not in the lowest position. Observed on 05/21/26 at 08:22 AM, R3 lay in bed. Her bed was in a low position, approximately six inches from the floor, with a fall mat at the bedside. On 05/20/26 at 03:08 PM, Administrative Nurse D said that she could not define or explain what frequent checks were because there was no way to quantify that time frame. Administrative Nurse D stated it was a task and was not something staff can put an exact time frame on. On 05/21/26 at 09:45 AM, CNA N said staff would leave the door to the bathroom propped open with a trash can. CNA N said they pull the privacy curtain if R3 is not using the bedside commode. CNA N said R3 is to have her bed in the lowest position with a	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 24 fall mat next to her bed and said these are the only fall interventions she is aware of. On 05/21/26 at 11:45 AM, CNA M said that R3's "Care Plan" documents that her bed is to be in the lowest position with a fall mat on the floor next to the bed. CNA M said that the plan documented the bedside commode was to be kept in the bathroom blocking the doorway. CNA M further stated that there was nothing in the bathroom that R3 was required to use and the door to the bathroom was propped open with a trash can per R3's request. The facility fall prevention protocol policy is undated and documents that each elder residing at this facility will be provided care that ensures the elder's environment remains as free from accident hazards as possible. The protocol further documents that an elder is considered to need high fall risk prevention protocols if the elder has had a fall while living at the facility.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F0690		

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F0690 SS = D	Continued from page 25 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that Resident (R) 2 received appropriate treatment and services to prevent urinary tract infections to the extent possible by failing to keep the urine collection bag attached to the nephrostomy(an artificial opening created between the kidney and the skin which allows for the urinary diversion) tubes below the level of the kidney. Findings included: - R2's Electronic Medical Record (EMR) revealed a diagnosis of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) urinary tract infection (UTI-an infection in any part of the urinary system), and a kidney infection. R2's 07/06/25 "Admission Minimum Data Set" (MDS) documented R2 had an indwelling catheter and took antibiotics. R2's 07/06/25 "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) documented R2 was in isolation for a UTI and had nephrostomy tubes in both kidneys, which staff are managing. R2's EMR contained "Discharge Instructions for Nephrostomy Tube Care," dated 05/15/26, which documented the nephrostomy tube drains urine from the kidney around the blockage to a bag outside the body. It instructed that the bag should always remain below the bladder. It should never be higher than the bladder. On 05/20/26 at 2:42 PM, R2 sat in the recliner in a reclined position. R2 had an apron with pockets on the chest for her urostomy bags. The bags were positioned in the pockets on her chest as she relaxed and watched television. On 05/20/26 at 2:58 PM, Certified Nurse Aide (CNA) P stated the staff transferred R2 with a Hoyer lift (total body mechanical lift). R2 was dependent on staff for all transfers. CNA P stated the staff knows R2 had nephrostomy tubes, and they were careful	F0690		

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F0690 SS = D	Continued from page 26 not to pull or tug on them. They always had the nurse present when they provided cares for R2. R2 had bags on the side of her bed to place the urine collection bags in while she was in bed. On 05/20/26 at 3:02 PM, Licensed Nurse (LN) G Stated the urine collection bags were to be in the bags on the sides of the recliner. They were never to be above the level of R2's bladder. LN G went in at that time and moved the bags. During an interview on 05/21/26 at 10:28 AM, Administrative Nurse D stated it was her expectation that staff always keep the urine collection bags below the level of the bladder to prevent back flow and infection. The facility's policy "Catheter and Nephrostomy Tube Care Policy" documented drainage bags are to remain below the level of the bladder or kidney insertion site.	F0690		