STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175387	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	**200 WILLOW RD , HILLSBORO, Kansas, 67063**

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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 2796746, 2986163, and 3090811. The census was 30. The sample included 15 residents.	F0000		
F0730 SS = F	Nurse Aide Perform Review – 12Hr/Year In- service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to complete an annual performance review at least once every 12 months for one Certified Nurse Aide (CNA), employed greater than one year. Findings included: - Review of five CNA personnel files, employed by the facility for greater than one year, revealed the following concern: Certified Nurse Aide (CNA) N, hired 12/04/2017, lacked an annual performance review. On 07/21/2026 at 02:30 PM, Administrative Nurse D stated the facility only completed annual performance reviews on full-time and part-time employees but did not complete annual performance reviews on as-needed (PRN) employees, such as CNA N. The facility's "Employee Handbook" included: PRN team members are scheduled no more than 19 hours per week. PRN team members must work at least two shifts per pay period or 4 shifts each calendar	F0730		

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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F0730 SS = F	Continued from page 1 month to remain employed. A performance review will be conducted once per year for each team member.	F0730		
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 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to the residents of the facility appropriately to prevent the potential for food borne bacteria. Findings included: - During an initial tour of the kitchen on 07/20/2026 at 09:02 AM, the following areas of concern were noted: 1. The front of the microwave had dried-on food on the inside. 2. The covered black plastic trash can had dried-on food and liquids. 3. A shelf holding gallon jugs of pancake syrup had spilled, dried syrup on the wire shelf.	F0812		

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F0812 SS = F	Continued from page 2 4. A shelf holding clean steam table pans had scattered food debris. 5. Two three-tiered wire carts used to transport food and drinks to the residents had multiple areas of rust. 6. Two hot carts used to transport residents' food to another dining room had multiple areas of dried-on food. 7. A bread cart had a covering of a sticky substance on the runners. 8. Six colored plastic cutting boards were heavily gauged and discolored. On 07/22/2026 at 09:13 AM, Dietary Staff BB confirmed the areas noted above needed to be added to the cleaning list. The facility policy for "Food Preparation and Handling," dated 10/17/2024, included: The facility will store, prepare, distribute, and serve food in accordance with professional standards for food safety services. Cutting boards will be washed and sanitized following each use.	F0812		
F0908 SS = F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record revise, the facility failed to ensure the walk-in freezer in one of one kitchen of the facility was in clean, safe operating condition. Findings included: - During an initial tour of the kitchen on 07/20/2026 at 09:02 AM, the following area of concern was noted: The inside of the walk-in freezer had a heavy build-up of frost on all areas, including multiple boxes of food. Review of the walk-in freezer temperatures, documented daily by staff, revealed the freezer stayed within the appropriate temperature range, and	F0908		

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F0908 SS = F	Continued from page 3 all foods in the freezer were solidly frozen. On 07/20/2026 at 10:43 AM, Administrative Staff A stated staff were installing rubber door flaps on the inside of the freezer at the door to help keep the cold air on the inside. A new door for the walk-in freezer had been ordered and would be installed next week. Administrative Staff A stated the food inside the freezer had not thawed and was safe to be served to the residents. The facility policy for "Food Preparation and Handling," dated 10/17/2024, included: The kitchen and equipment will be kept clean, neat, orderly, and well-maintained.	F0908		
F0636 SS = E	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.	F0636		

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F0636 SS = E	Continued from page 4 (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (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 complete the Care Area Assessment (CAA) analysis related to a “Comprehensive Minimum Data Set” (MDS), for Residents (R)2, R9, R12, R21, R29, R33, and R38 to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. Findings included: - Review of residents’ most recent comprehensive MDS documentation revealed the triggered CAA	F0636		

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F0636 SS = E	Continued from page 5 lacked completion as follows: 1. R2's "Significant Change in Status MDS," dated 02/11/2026, lacked completion of CAAs dated 02/27/2026 for Cognitive Loss/Dementia, Communication, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. 2. R9's "Annual MDS," dated 12/07/2026, lacked completion of CAAs dated 12/16/2026 for Cognitive Loss/Dementia, Visual Function, Functional Abilities (Self-care and Mobility), Urinary Incontinence, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcers, and Psychotropic Drug Use. 3. R12's "Annual MDS," dated 02/21/2026, lacked completion of CAAs dated 02/21/2026 for Cognitive Loss/Dementia Care, Functional Abilities (Self-Care and Mobility), and Pain. 4. R21's "Annual MD," dated 08/09/2026, lacked completion of CAAs dated 08/25/2025 for Cognitive Loss/Dementia, Functional Abilities (Self- Care and Mobility), Communication, Falls, and Psychoactive Drug Use. 5. R29's "Modified Admission MDS," dated 09/05/2025, lacked completion of CAAs dated 09/05/2025 for Cognitive Loss/Dementia, Communication, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer/Injury, Psychotropic Drug Use, and Pain. 6. R33 's "Annual MDS," dated 11/09/2025, lacked completion of CAAs dated 11/19/2025 for Functional Abilities (self-care mobility), Urinary Incontinence and Indwelling Catheter, Nutritional Status, and Dental. 7. R38's "Annual MDS," dated 05/24/2025, lacked completion of CAAs dated 05/29/2025 for Cognitive Loss/Dementia , Visual Function, Communication, Functional Abilities (Self-Care and Mobility), Urinary Incontinence and Indwelling Catheter, Falls, Pressure ulcer/injury, and Psychotropic Drug Use. On 07/22/2026 at 02:32 PM, Administrative Nurse E reported the facility used the Resident Assessment Manual (RAI) for guidance to complete the MDS and CAAs for comprehensive assessments. She reported she was not aware the CAA completion should include the location of the information and resource	F0636		

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F0636 SS = E	Continued from page 6 materials that led to the individualized analysis for the triggered areas of the CAA to develop the care plan until she received training on 04/26/2026. She verified the CAA documentation for the above named residents lacked source documentation of information to indicate the analysis of the data collected, other than the narrative for the location of the data that triggered the CAA, and lacked analysis keeping with the guidance provided in the RAI Manual. The “Resident Assessment Instrument” (R.A.I.) Manual, titled “The Care Area Assessment (CAA) Process and Care Plan Completion,” dated 2025, documentation included “. . . Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident’s care plans that will be used to provide services to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being. The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based “Trigger” conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appears in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process. CAA(s) completion is required for comprehensive assessments."	F0636		
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	F0552		

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F0552 SS = D	Continued from page 7 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: Based on interview and record review, the facility failed to inform Resident (R) 1 and R32 and/or their representatives regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included: 1. R1's Electronic Medical Record (EMR) listed a Physician's Order for buspirone (antianxiety- a class of medications that calm and relax people), 5 milligrams (mg) tablets, give one tablet by mouth three times a day for anxiety, dated 03/03/2026. R1's EMR documented an order for lorazepam (antianxiety- a class of medications that calm and relax people) 0.5 mg tablet, give one tablet by mouth every four hours as needed for anxiety/restlessness, dated 05/29/2026. R1's EMR lacked evidence that R1, or her representative, received education and/or informed consent with regard to the buspirone and lorazepam. On 07/20/2026 at 09:09 AM, R1 sat in her recliner wearing her glasses and hearing aids. R1 reported she felt safe and the staff listened to her even though she did not speak much. R1 could not recall what medications she was administered. 2. R32's EMR documented an order for Remeron (antidepressant- a class of medications used to treat mood disorders)15 mg tablet, give one tablet by mouth at bedtime for insomnia (inability to sleep), dated 06/30/2026. R32's EMR lacked evidence that R32, or her representative, received education and/or informed consent with regard to the Remeron. On 07/20/2026 at 09:24 AM, R32 was in her bed, and she reported she did not feel good. On 07/21/26 at 01:28 PM, Licensed Nurse (LN) G reported that the psychoactive consents were completed by Administrative Nurse D.	F0552		

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F0552 SS = D	Continued from page 8 On 07/22/2026 at 11:48 AM, Administrative Nurse D reported she had not completed an informed consent for R32' s Remeron. Administrative Nurse D produced two informed consent forms for R1. The buspirone consent had a date signed by Administrative Nurse D documented 03/04/2026; the durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) signature had no date; LN G signed as a witness on 07/22/2026. The lorazepam consent had a date signed by Administrative Nurse D, documented 05/29/2026; the DPOA signature had no date; LN G signed as a witness on 07/22/2026. Administrative Nurse D reported that the forms were completed that day. On 07/22/2026 at 12:22 PM, R1's DPOA was in the dining room; she reported that she had just signed the informed consent forms and said that she did not think to date the forms. She reported that there were no other signatures or dates on the informed consent forms when she signed them. On 07/22/2026 at 01:33 PM, Administrative Nurse D reported that she expected to have informed consents for all psychotropic medications completed upon admission or before a resident would start a psychotropic medication. The facility's policy "Psychotropic Medication Use" dated 03/2026 lacked documentation in regard to completing an informed consent. The facility's "Informed Consent Form," undated, documented that the proposed treatment will not be started by the facility until this signed consent is returned to the facility. Please complete this document prior to initiation of any treatment of chemical or physical restraint, or psychoactive drugs.	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,	F0605		

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F0605 SS = D	Continued from page 9 and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F0605		

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F0605 SS = D	Continued from page 10 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §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:	F0605		

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F0605 SS = D	Continued from page 11 Based on observation, record review and interviews, the facility failed to ensure Resident (R) 1's as needed (PRN) psychotropic medication (alters mood or thoughts) had a 14 day stop date, or a specified duration with a physician rationale for extended use. Additionally, the facility failed to monitor R25's for target behaviors or side effects of the psychotropic medications. Findings included: - R1's Electronic Medical Record (EMR) revealed a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R1's 06/09/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R1's MDS revealed he was administered an anti-anxiety medication. R1's 06/23/2026 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R1 was administered high-risk psychotropic medications. R1 would be at high risk for falls. R1's "Care Plan" dated 03/30/2026 instructed staff to administer antianxiety medications as ordered and to monitor and document side effects and effectiveness. R1's EMR noted an order for lorazepam 0.5 milligrams (mg), one tablet by mouth, every four hours as needed for anxiety/restlessness, dated 05/29/2026. The order lacked a stop date. On 07/20/2026 at 09:09 AM, R1 sat in her recliner wearing her glasses and hearing aids. R1 reported she felt safe here and the staff listened to her even though she did not speak much. R1 could not recall what medications she was administered. On 07/21/2026 at 02:42 PM, Licensed Nurse (LN) G reported that any as-needed psychotropic medication orders required a 14-day stop date. LN G reported that the nurse who documented the order in EMR was responsible for documenting a stop date. On 07/21/2026 at 04:30 PM, Administrative Nurse D reported she expected all as needed psychotropic medications to have a 14 day stop date to have the medication reassessed.	F0605		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	**200 WILLOW RD , HILLSBORO, Kansas, 67063**

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F0605 SS = D	Continued from page 12 The facility's policy "Psychotropic Medication Use" dated 03/2026 documented that any PRN psychotropic medication, such as anti-anxiety medication, will only continue for a duration of 14 days. If the medication must continue past the 14 days, it must have a physician-explained rationale and a duration of no more than 6 months. - R25's Electronic Medical Record (EMR) documented the following diagnoses: depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and insomnia (the inability to sleep). R25's "Admission Minimum Data Set" (MDS), dated 06/25/2026, documented he had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. He received antidepressant medications (medications used to treat the signs and symptoms of depression) during the assessment process. R25's "Psychotropic Drug Use Care Area Assessment" (CAA), dated 06/25/26, documented R25 had antidepressant medications, which placed him at risk for falls. R25's "Care Plan," dated 06/18/26, lacked staff instruction regarding the administration and monitoring of target behaviors and side effects of psychotropic drug use. R25's EMR documented the following physician's orders: Trazodone (an antidepressant medication), 50 milligrams (mg), by mouth (PO), at bedtime (HS), for a diagnosis of insomnia, ordered 06/18/2026. Sertraline (an antidepressant medication), 50 mg, PO, in the morning (AM), for a diagnosis of depression, ordered 06/19/2026. Bupropion (an antidepressant medication), 300 mg, PO, in the AM, for a diagnosis of depression, ordered 06/19/2026. R25's "Medication Administration Record" (MAR) for June and July 2026 revealed he received the medications, as ordered. R25's EMR lacked documentation of monitoring for target behaviors or side effects of the psychotropic medications. On 07/22/2026 at 08:50 AM, Licensed Nurse (LN) G stated staff monitors for side effects and target	F0605		

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F0605 SS = D	Continued from page 13 behaviors on residents who receive psychotropic medications every shift. On 07/22/2026 at 08:55 AM, Administrative Nurse D stated it was the expectation for staff to monitor psychotropic medications each shift. Administrative Nurse D stated staff instruction for residents receiving psychotropic medications should be included in their care plans. The facility policy "Psychotropic Medication Use," revised 03/2026, included: The staff shall monitor for target behaviors related to psychotropic medication every shift. The facility policy for "Care Planning," revised 03/2026, included: The facility shall develop and implement a comprehensive person-centered care plan for each resident to meet each resident's medical, nursing, and psychosocial needs.	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.	F0628		

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F0628 SS = D	Continued from page 14 §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 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:	F0628		

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F0628 SS = D	Continued from page 15 (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; (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	F0628		

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F0628 SS = D	Continued from page 16 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 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	F0628		

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F0628 SS = D	Continued from page 17 prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to notify the State Ombudsman of two resident discharges to the hospital, regarding Resident R1 and R3, as required. Findings included: 1. R1's Electronic Medical Record (EMR) documented that she admitted to the hospital on 05/25/2026. The EMR lacked documentation that the State Ombudsman had been notified of the resident's hospital admission. The facility was unable to provide evidence upon request. 2. R3's EMR documented he admitted to the hospital on 07/09/2026. The EMR lacked documentation that the State Ombudsman had been notified of the resident's hospital admission. The facility was unable to provide evidence upon request. On 07/22/2026 at 10:30 AM, Social Services X stated she had not notified the State Ombudsman of R1 and R3's hospital admissions. The facility policy for "Admission, Transfer and Discharge", revised 01/2026, included: The State Ombudsman will be notified of all transfers and discharges.	F0628		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F0655		

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F0655 SS = D	Continued from page 18 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide a written baseline care plan to Resident (R) 32, and R37. Findings include: 1. R32's Electronic Medical Record (EMR) lacked documentation that a written baseline care plan was given to or reviewed by R32 or a representative since she was admitted on 06/30/2026.	F0655		

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F0655 SS = D	Continued from page 19 On 07/20/2026 at 09:24 AM, R32 was in her bed, and she reported she did not feel good. 2. R37's EMR lacked documentation that a written baseline care plan was given or reviewed by R37 or a representative since she was admitted on 07/15/2026. On 07/21/2026 at 08:01 AM, R37's durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) reported that she had no care plan discussed with her since R37 was admitted to the facility. On 07/21/2026 at 04:13 PM, Licensed Nurse (LN) G reported that the nurse would complete the base line care plan on admission that was documented in the EMR in the assessment tab. On 07/21/2026 at 04:15 PM, Administrative Nurse D reported that she expected the baseline care plan to be completed within 48 hours of admission. The facility's policy "Baseline Care Plan" dated 10/17/2024, documented this facility will develop an initial person-centered care plan within the first forty-eight (48) hours of admission for every resident. A baseline care plan will provide instructions for care of the resident. Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among all facility staff members, increase resident safety and safeguard against adverse events that are most likely to occur in the immediate days after admission prior to development of the comprehensive care plan and to ensure the resident and representative are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan or a copy of the baseline care plan.	F0655		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents received	F0677		

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F0677 SS = D	Continued from page 20 assistance with activities of daily living (ADL) including nail care for Resident (R)1, and R32. Findings included: 1. R1's Electronic Medical Record (EMR) revealed diagnoses of anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) R1's 06/09/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R1's MDS revealed she required maximal assistance with personal hygiene. R1's 06/23/2026 " Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented R1 required assistance with all ADLs to ensure safety. R1's "Care Plan" dated 03/15/2026 instructed staff to keep R1's fingernails short. R1's "Care Plan" dated 06/23/2026 instructed staff that R1 required moderate assistance with personal hygiene. On 07/21/2026 at 07:55 AM, R1 sat in the dining room as she was eating yogurt. She had a visitor and reported she was doing fine. R1 had long fingernails and nail polish that was chipped off all the nails. On 07/21/2026 at 01:52 PM, R1 was administered her breathing treatment by Licensed Nurse (LN) G in her room. R1's fingernails were long, and they all had chipped nail polish. LN G reported that Activity Staff K had not done a nail manicure activity lately, and that is when the residents would have new nail polish applied. On 07/22/2026 at 08:00 AM, R1 sat in her recliner with her eyes closed; her fingernails remained the same as yesterday's observation. 2. R32's EMR revealed diagnoses of diabetes mellitus and needing assistance for personal care. R32's 07/07/2026 "Admission MDS" documented a BIMS score of three, indicating severely impaired cognition. R32's MDS revealed she required moderate assistance for personal hygiene.	F0677		

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F0677 SS = D	Continued from page 21 R32's 07/13/2026 "Functional Abilities (Self-Care and Mobility) CAA" did not trigger. R32's 07/13/2026 "Activities CAA" documented R32 had visual and some hearing impairment. She has physical limitations such as weakness and pain. Her disability may prevent her from attending/participating in some activities, which will cause her to want to stay in her room often and become isolated and lonely. R32 would be care plan is initiated to encourage social interaction and active participation. R32's "Care Plan" dated 07/13/2026 staff instructed to ask yes/no questions to determine R32's needs. R32's "Care Plan" dated 07/20/2026 lacked direction for staff for R32's preferences of nail care and staff assistance required. On 07/20/2026 at 03:39 PM, R32 was assisted to her recliner by Certified Nurse Aide (CNA) P. R32's fingernails were long and had brown substance under some of the fingernails; all of her fingernails had chipped nail polish noted on them. On 07/22/2026 at 07:58 AM, R32 sat in the dining room drinking coffee. R32's her nails remained with long, chipped nail polish on all the fingernails and brown substance under some of her nails. On 07/21/2026 at 01:23 PM, CNA P reported that residents' fingernails are trimmed and cleaned on shower days and as needed. CNA P reported that the nurse would cut the diabetic residents' nails. On 07/22/2026 at 11:50 AM, Activity Staff Z (Activity Director) reported that she had not completed a manicure activity for about 2 months now, and she was the staff member who painted the residents' fingernails. On 07/22/2026 at 12:40 PM, Administrative Nurse D expected the staff to clean and trim residents' fingernails. Administrative Nurse D reported that activities would complete the manicures and new nail polish. Administrative Nurse D reported she was unsure when activities had completed that activity last but expected residents to have nice nail polish on their nails. The facility's policy "Cleaning and Trimming Nails" dated 03/2026, documented that cleaned and trimmed fingernails and toenails are important for overall health. Bacteria often collect under and	F0677		

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F0677 SS = D	Continued from page 22 around nailbeds. This facility is committed to providing high-quality care to all residents residing in the facility.	F0677		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, and record review, the facility failed to monitor Resident (R) 38's nutritional and hydration status during an acute change of condition. The facility failed to monitor for complications related to R2's multiple bruises and a skin tear. Findings included: - R38 Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dysphagia (difficulty swallowing), stage four chronic kidney disease (disease where the kidneys were moderately or severely damaged and were not working as well as they should be to filter waste from the blood), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and Influenza A (highly contagious viral infection). R38's "Annual Minimum Data Set (MDS)," dated 05/24/2025, documented a "Brief Interview for Mental Status (BIMS)" score of five, which indicated severe cognitive impairment. He had functional limitations in range of motion (ROM) to both sides of his upper and lower extremities. He required staff touch and set up assistance with eating and did not exhibit swallowing or choking issues. R38 was 65 inches in height and weighed 222 pounds (lbs). R38's "Quarterly MDS," dated 11/24/2025, documented a BIMS score of nine, which indicated moderate cognitive impairment. His weight was 208	F0684		

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PARKSIDE HOMES	**200 WILLOW RD , HILLSBORO, Kansas, 67063**

(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
F0684 SS = D	Continued from page 23 lbs, which was a 14lb or 7.5% weight loss from the previous assessment. R38's "Discharge Return Anticipated MDS," dated 01/23/2026, documented R38 was discharged from the facility and was sent to the hospital with an anticipated return. R38's "Nutritional Status Care Area Assessment (CAA)" documented the CAA triggered due to high Body Mass Index (BMI- the body calculation of resident body fat) and a no-salt-added diet order. He ate well at meals with a stable weight. He had no complications. R38's 11/25/2025 "Care Plan" directed that R38's recommended diet was a mechanical soft level two (mechanically altered diet where the foods are moist, with soft texture for easy swallowing). R38 and his representative requested not to follow the recommended diet. His representative signed a risk versus benefit agreement for him to be allowed to have a regular diet. He and his representative declined any further speech (ST) evaluations and stated that, no matter the outcome, they will continue to sign a waiver. He usually ate 50-100% at meals. He had his own teeth without any chewing or swallowing difficulty noted. His BMI indicated obesity (severe overweight), but he was stable. R38 had diuretic orders which may impact fluid shifts/weight trends. R38's EMR revealed the following, indicating a change in condition: A "Health Status Note," dated 01/18/2026 at 03:15 PM, documented R38 woke up with a low-grade fever and moist cough. His temperature was 99.0 degrees Fahrenheit (F), and his lungs sounded clear. R38 had a pleasant mood; he ate a cinnamon roll and drank juice for breakfast. He remained in his room due to a cough and per his representative's request. On 01/18/2026 at 08:10 PM, R38's EMR noted his temperature was 100 degrees F, his blood pressure was 183/103 millimeters of mercury (mmHg), his pulse was irregular at 102 beats per minute (bpm), and his oxygen saturation was 96% on room air. A "Health Status Note" on 01/19/2026 at 04:18 PM, documented while R38 was out of the facility at a scheduled physician visit, the physician's office called and reported R38 tested positive for influenza A. The facility received an order for Tamiflu (medication used to treat influenza) 75 milligrams	F0684		

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F0684 SS = D	Continued from page 24 (mg) twice a day for five days. Staff notified R38's representative. A "Health Status Note," dated 01/21/2026 at 05:47 AM, documented that R38 started Tamiflu on 01/20/26. His oxygen saturation had been 88 to 92% on oxygen therapy with respirations of 20 to 32 per minute. R38 had coarse lung sounds, and staff checked on him frequently. A "Health Status Note" on 01/23/2026 at 10:32 AM documented that the nurse was called to R38's room due to him not responding with a dry brief. The nurse notified R38's provider and obtained an order, then notified his representative. R38 left the facility at 09:48 AM via emergency medical services (EMS), and the nurse called report to the hospital at 09:49 AM. Review of R38's meal percentage EMR documentation from 01/15/2026 to 01/23/2026 revealed the following: On 01/15/2026 and 01/16/2026, R38 ate 76 to 100% at breakfast, lunch, and dinner. There was a lack of evidence of meal percentage documentation on 01/17/26 for breakfast, lunch, or dinner. On 01/18/2026, there was a lack of evidence of meal percentage documentation for breakfast or lunch. R38 ate 51 to 75% at dinner. On 01/19/2026, R38 ate 26 to 50% at breakfast and lunch. There was a lack of evidence of meal percentage documentation for dinner. On 01/20/2026, there was a lack of evidence of meal percentage documentation for breakfast. R38 ate 0 to 25% at lunch and drank a protein shake. R38 ate 0 to 25% at dinner. On 01/21/1026, R38 ate 0 to 25% for breakfast and dinner. There was a lack of evidence of meal percentage documentation for lunch. On 1/22/2026, R38 ate 0 to 25% for breakfast and dinner. There was a lack of evidence of meal percentage documentation for lunch. On 07/21/2026 at 09:39 AM, Certified Nurse Aide (CNA) P stated R38's representative visited every day and was highly involved in his care. CNA P stated R38 went to the hospital because he was not responsive, and he had influenza. He was coughing	F0684		

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F0684 SS = D	Continued from page 25 up green mucus and rattling when he breathed. CNA P stated she offered R38 house shakes, which he would take a couple of sips of, but he would not eat and would only drink water occasionally. She stated he loved Dr. Pepper, but he barely drank that as well. CNA P stated R38's intake decreased over a period of a few weeks. She stated staff documented in the EMR for each meal offered and documented the percentage eaten. She stated the nurse monitored the resident's intake and reported it to the physician. CNA P stated it seemed they noticed his change in condition on the day they sent him out. On 07/21/2026 10:20 AM, Licensed Nurse (LN) G stated the interventions to treat residents were communicated through the care plan, messages, and report. She stated staff monitored for changes in condition through different assessments. When residents had condition changes, staff monitored their vital signs and encouraged fluids based on their area of decline. LN G stated the CNAs notified the nurse of changes, and the nurse assessed the resident, then notified the physician. She stated the CNAs documented in the EMR what the residents ate or drank, but she did not review that documentation because she did not have time and depended on the CNAs to let her know if the resident ate or not. LN G stated she remembered when R38 stopped eating as much when he had influenza; he did not have an appetite, and his kidneys were impaired. She stated she did not recall if R38 received fluids or not, as that would be a better question for the CNA. LN G stated she did not recall if staff notified her that R38 coughed up green mucus or was coughing up more. She stated she would implement standing orders and notify the physician and/or family of changes. LN G stated staff should have documented meal intake and notified the nurse of the intake to maintain their medical record. On 07/21/2026 at 02:14 PM, Administrative Nurse D reviewed the EMR related to the meal intake and associated change in condition. She confirmed the lack of documented intake monitoring that would be expected during R38's change in condition. - R2's Electronic Medical Record (EMR) revealed a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and dementia (a progressive mental disorder characterized by failing memory and confusion) R2's 02/11/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental	F0684		

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F0684 SS = D	Continued from page 26 Status (BIMS); no BIMS interview completed as resident was rarely/never understood. Staff assessment completed indicating severely impaired cognition. R2's MDS revealed no behaviors noted, and she required total dependence from staff for activities of daily living (ADLs). R2's 02/27/26 "Care Area Assessment" (CAA) section revealed none of the CAAs were documented that triggered. R2's "Care Plan" dated 04/04/2022, staff were instructed to observe R2's skin during daily cares and report concerns to the charge nurse. R2's "Care Plan" dated 11/03/2023 instructed staff to place a floormat beside the bed. R2's "Care Plan" dated 11/05/2024, staff were instructed to apply Tubi-grips (elasticated tubular bandage designed to provide tissue support in treating strains, sprains, soft tissue injuries, general edema, and tissue protection) to both arms for protection apply in the morning and removed in the evening. R2's "Care Plan" dated 04/14/2026, staff were instructed to apply Tubi-grips to both arms for protection, apply in the morning and remove in the evening to prevent skin issues. At times, durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to)will demand sleeves/Tubi-grip to be removed, although DPOA had been educated on the benefits of skin protection in preventing future wounds. R2's "Weekly Skin Check" reviewed from 05/12/2026 and 07/08/2026 revealed no documentation for any bruises on R2's arms or right hand middle finger. R2's "Weekly Skin Issues" reviewed from 05/12/2026 and 07/08/2026 revealed no documentation for any bruises on R2's arms or right hand middle finger. R2's "Hospice Nurse Visit Log" dated 06/10/2026 documented bruising on both upper forearms. The documentation lacked sizes, colors, and whether facility staff was notified. On 07/21/2026 at 11:10 AM, Certified Nurse Aide (CNA) Q and Certified Medication Aide (CMA) R assisted R2 to bed when they used the mechanical lift and transferred R2 to her bed, observed several	F0684		

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F0684 SS = D	Continued from page 27 purple bruises on both her posterior forearms and a purple bruise on her right hand middle finger. CMA R operated the lift, and CNA Q did not support R2's legs while she was in the lift. CMA R removed her pants with no bruises or skin issues noted on R2's legs. On 07/22/2026 at 08:01 AM, R2 was lying in her bed moving her arms around and mumbling her bed was in low position, and no fall mat was noted on the floor. R2 had no Tubi grips on her arms, and the bruises remained the same on her arms and right-hand middle finger as in the 07/21/2026 observation. R2's right arm had six purple bruises noted on the posterior forearms ranging in approximate sizes of 1 centimeter (cm) diameter to 3 cm diameter; R2's right middle finger purple bruise approximate size of 1 cm diameter. R2's left forearm purple colored bruises noted, five ranging in approximate size of 1cm to 3 cm in diameter. The new fall mat was in the bathroom, folded in a plastic bag. On 07/22/2026 at 08:58 AM, CMA R reported that she was pretty sure a new fall mat was delivered before she left work around 06:00 PM on 07/21/2026. CMA R looked in R2's bathroom and reported that the new fall mat was in the bathroom, folded and still in the plastic wrap, and reported well no one laid it down. CMA R reported that R2's husband would not allow the staff to apply any type of arm protectors. CMA R observed several bruises on R2's arms and right hand middle finger and reported that R2 would pinch her arms at times, and that is why she has bruises. On 07/22/2026 at 09:00 AM, CNA Q reported she did not notice that R2 did not have a fall mat on the floor this morning when she gave care earlier. CNA Q reported she was not aware if R2 required any type of arm protectors. On 07/22/2026 at 09:05 AM, Licensed Nurse (LN) G reported that R2's fall mat was delivered to her room on 07/21/2026 in the evening before she left work. LN G reported that CNA O removed the old fall mat from R2's room. LN G reported that R2's family requested she not wear arm protectors during the summertime as it would be too hot for her. LN G reported that R2 would bruise easily with transfers and sometimes the husband would grab at her arms when he assisted her with her meal. LN G reported that she did see all the purple bruises on R2's arms when she applied the dressing to her right elbow skin tear on 07/21/2026. LN G reported she expected the staff to use all the fall interventions on	F0684		

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F0684 SS = D	Continued from page 28 the care plan. LN G reported that the nurse would complete the weekly skin check and should document all areas of concern. 07/22/2026 at 09:10 AM, Administrative Nurse D expected staff to always have all fall interventions in place. On 07/22/2026 at 01:31 PM, CNA M reported she would notify the nurse verbally if a resident were to have a new bruise or skin tear or any new skin issue. CNA M reported that the staff would not document that anywhere; they just verbally let the nurse know. 07/22/2026 at 01:37 PM, Administrative Nurse D reported she expected the nurse to complete a weekly skin check in EMR that would include any skin issues; she also expected the staff to complete an incident report for skin tears and bruises if unknown injury. On 07/22/2026 at 02:30 PM, Administrative Staff A reported that the bruises were not documented in R2's EMR; She expected them to be documented. The facility's policy "Skin Integrity" dated 03/2026 documented, residents who are admitted will have every effort made in order to assure that their skin integrity is maintained though correlated efforts from the interdisciplinary care team. The policy lacked documentation for bruises.	F0684		
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,	F0880		

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F0880 SS = D	Continued from page 29 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. §483.80(f) Annual review.	F0880		

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F0880 SS = D	Continued from page 30 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 interviews, observation, and record review, the facility failed to implement adequate infection control practices related to respiratory equipment for Resident (R) 1 and R37, and hand hygiene during incontinence care for R2. Findings included: 1. On 07/20/2026 at 09:09 AM, R1 sat in her recliner wearing her glasses and hearing aids. A portable oxygen tank was observed on the back of R1's wheelchair; the nasal cannula tubing was draped over the tank, and the nose part touched the tank. On 07/21/2026 at 07:59 AM, R1's oxygen tubing laid on the floor. 2. On 07/20/2026 at 10:49 AM, R2 had a fall mat in her bathroom; the fall mat had frayed open areas noted in the corners. On 07/20/2026 at 03:37 PM, R2 was in her low bed with a fall mat on the floor that had worn areas in the corners and cracks noted on the surface. On 07/21/2026 at 02:30 PM, Consultant Staff HH (Hospice Nurse) looked at R2's fall mat and reported that the fall mat in R2's room should be replaced as it was cracked and had uncleanable surfaces. Consultant Staff HH reported that hospice did not supply that fall mat. On 07/21/2026 at 02:38 PM, Licensed Nurse (LN) G reported that fall mats should not have cracks on them and that the family would appreciate a new mat. On 07/21/2026 at 04:15 PM, Administrative Nurse D reported that the fall mats should have a cleanable surface and the fall mat would be replaced for R2. 3. 07/20/2026 12:17 PM R37 had oxygen tubing wrapped up and laid on top of her overbed table. On 07/20/2026 at 03:38 PM, R37 slept in her recliner; a portable oxygen tank was observed on the back of R37's wheelchair. The nasal cannula tubing was draped over the wheelchair seat, and the nose part lay on the pad of the wheelchair seat. On 07/21/2026 at 02:21 PM, R37's nasal cannula lay	F0880		

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F0880 SS = D	Continued from page 31 on the floor in her room. On 07/21/2026 at 02:14 PM, Certified Medication Aide (CMA) R reported that all oxygen tubing, when not in use, should be placed in a bag, as she looked at R1's oxygen tubing laid on the wheel of her wheelchair. On 07/21/2026 at 02:17 PM, LN G reported that all oxygen cannula's/mask should be placed in a bag when not in use. On 07/21/2026 at 04:23 PM, Administrative Nurse D expected all oxygen tubing to be placed in a bag when not in use. 4. On 07/21/2026 at 11:01 AM, CMA R and Certified Nurse Aide (CNA) Q provided incontinent care to R2. CMA R cleansed R2's buttocks, then removed her gloves to retrieve a brief liner from the bathroom. CMA R applied new gloves; no hand hygiene was performed. CNA Q cleansed R2's peri-area. CNA Q left her soiled gloves on after she cleansed R2 as she assisted R2 with dressing R2. CMA R removed her gloves with no hand hygiene performed. CNA Q and CMA R transferred R2 to her recliner with the mechanical lift. CNA Q picked up the package of cleansing wipes and extra brief and placed those items into R2's bathroom while wearing the same gloves she used to cleanse R2. CNA Q removed her gloves, and no hand hygiene was performed. CMA Q propelled R2 down the hallway to the television lounge; she then stopped at the nurse's desk and exited the facility; no hand hygiene was performed. On 07/21/2026 at 01:12 PM, CNA Q reported that she should have removed her gloves and performed hand hygiene after she cleaned R2's peri area. On 07/21/2026 at 02:14 PM, CMA R reported that she should have washed her hands after she removed her gloves before she placed a new pair on when she completed incontinent care to R2. On 07/21/2026 at 02:38 PM, LN G reported that the staff should perform hand hygiene every time they remove their gloves. On 07/21/2026 at 04:23 PM, Administrative Nurse D reported she expected all staff to perform hand hygiene after they remove their gloves. The facility's policy "Hand Hygiene" dated 03/2026 documented the facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable	F0880		

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F0880 SS = D	Continued from page 32 environment and to help prevent the development and transmission of communicable diseases and infections. Key recommendations for hand hygiene included before and after removing gloves. The facility did not provide a policy for the care of respiratory equipment.	F0880		
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and record review, the facility failed to ensure Resident (R)1's bed was in safe condition. Findings included: - R1's Electronic Medical Record (EMR) revealed a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R1's 06/09/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R1's MDS revealed she required moderate assistance with bed mobility. R1's 06/23/2026 "Falls Care Area Assessment" (CAA) documented: Adeline is taking high-risk medications Adeline had a fall resulting in a fall. She is continually a high fall risk. R1's "Care Plan" dated 03/16/2026 instructed staff R1 preferred to have bed rails on her bed to help her reposition in bed easier. R1's "Bed Rail Assessment" dated 03/14/2026 at 07:27 PM documented siderails/assist bar were indicated and serve as an enabler to promote independence; R1 had expressed a desire to have an assist bar. R1's "Bed Rail Assessment" dated 05/20/2026 at 05:57 PM documented siderails/assist bar were not	F0909		

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F0909 SS = D	Continued from page 33 indicated at this time. R1's "Bed Rail Assessment" dated 05/24/2026 at 05:44 PM documented siderails/assist bar was not indicated at this time. On 07/20/2026 at 09:09 AM, R1 sat in her recliner wearing her glasses and hearing aids. R1 reported she felt safe here and the staff listened to her even though she did not speak much. R1 had a bed assist bar on each side of her bed upright. The bed assist bar on the left side of the bed was quite loose; it freely moved away from the bed. On 07/21/2026 at 10:17 AM, R1's two bed assist bars remained on each side of her bed upright, and the left bed assist bar remained loose. On 07/21/2026 at 02:14 PM, Certified Medication Aide (CMA) R reported that R1 never used the bed assist bars on her bed and did not realize they were loose. CMA R reported that the staff communicates with maintenance in writing when something needs fixed. On 07/22/2026 at 10:13 AM, Maintenance Staff U (Maintenance Supervisor) reported that he did not complete a monthly check of bed positioning devices. He reported that once the device is applied to a resident's bed, we just remove the device at discharge. Maintenance Staff U reported that R1's positioning bar was loose as he looked and moved the bed assist bar attached to R1's bed at this time. Maintenance Staff U reported that the bed was the facility's bed and not provided by hospice. On 07/22/2026 at 01:33 PM, Administrative Nurse D reported that she was not aware that R1 had two bed rail assessments that documented R1 did not require the rails on her bed. Administrative Nurse D expected the nurse to communicate changes in assessments so the bed assist bars could be removed. On 07/22/2026 at 02:15 PM, Administrative Staff A reported that the staff would communicate to the maintenance staff in writing if anything needed to be repaired. She reported she was uncertain if the bed assist bars were required to be inspected. The facility's policy "Electric Bed" dated 03/2026 documented the facility would conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and	F0909		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0909 SS = D	Continued from page 34 purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. Report any malfunctions to the maintenance department.	F0909		
F0921 SS = D	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: Based on observation, record review, and interview, the facility failed to provide housekeeping and maintenance services to ensure a safe and sanitary environment in the facility laundry. Findings included: - On 07/22/2026 at 09:58AM, laundry tour with Housekeeping/Maintenance Staff U revealed the following concerns: 1. The floor in front of the washers was unsanitary with missing paint/sealant on the concrete floor approximately three inches by three feet section. 2. The floor throughout the laundry processing area was unsanitary due to missing paint/sealant on the concrete floor in an approximately three-inch by three-foot section. 3. The intake ventilation unit had peeling sheetrock above the screen which measured approximately six inches by five inches. On 07/22/2026 at 10:03 AM, Administrative Staff A and Housekeeping/Maintenance Staff U confirmed the laundry floor and sheetrock surrounding the ventilation intake were in need of repair to provide a safe and sanitary environment for the laundry staff processing residents' linen. The facility policy titled “Laundry Infection Control and Prevention Policy,” dated 03/2026, documented that the facility must provide and maintain a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections.	F0921		

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F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F0732		

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F0732 SS = C	Continued from page 36 standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to display accurate, publicly accessible, and identifiable staffing information, on a daily basis, for the 30 residents who resided in the facility. Findings included: - Review of the facility's "Daily Staffing Sheets" from 06/20/2026 through 07/20/2026 revealed that the actual hours worked and the facility name had not been completed on the daily staffing sheets. On 07/21/2026 at 02:30 PM, Administrative Staff B confirmed the daily staffing sheets lacked the actual hours worked and the facility name, as required. The facility policy for "Posting Daily Nurse Staffing Form", dated 01/2025, included: The Daily Nurse Staffing Form will include, but is not limited to, the facility name, current date, total number, and actual hours worked by Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA).	F0732		
F0814 SS = C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly by failing to ensure the lid of the dumpster was kept closed. Findings included: - During the initial tour of the kitchen on 07/20/2026 at 09:02 AM, observation revealed the covers of the dumpster were open. On 07/21/2026 at 10:30 AM, the dumpster lid	F0814		

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F0814 SS = C	Continued from page 37 remained open. On 07/22/2026 at 09:13 AM, the dumpster lid was held open by trash bags within the dumpster. On 07/22/2026 at 09:13 AM, Dietary Staff BB confirmed the lid to the dumpster was not always kept closed. The facility was unable to provide a policy regarding the dumpsters.	F0814		