

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER SHAWNEE GARDENS HEALTHCARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6416 LONG STREET , SHAWNEE, Kansas, 66216			
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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 3117907, 3106922, 3076067, 3011749. The census was 109. The sample included 22 residents.			F0000			
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 in one of the kitchens. Findings included:			F0812			

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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F0812 SS = F	Continued from page 1 - During an initial tour of the kitchen on 08/03/2026 at 07:42 AM, the following areas of concern were noted: 1. One three-tiered black plastic cart used for food preparation had two melted areas on the second tier. 2. A black wire rack in the refrigerator walk-in had a build-up of food debris. 3. A wire rack holding clean pots and pans had multiple areas of rust. 4. Thirty-five plastic trays, used for serving residents meals, were put away wet. 5. A large plastic container holding dry rice lacked a lid. 6. A plastic container of uncooked oatmeal was left uncovered. During an initial tour of two kitchenettes on 08/03/2026 at 08:00 AM, the following area of concern was noted: 1. The microwave in each location had a build-up of dried food on all inside surfaces of the microwaves. On 08/05/2026 at 07:56 AM, Dietary Staff BB confirmed the listed areas of concern. The facility policy, "Sanitation of Dining and Food Service Areas", dated 2020, included: The Dining Services staff will uphold sanitation of the dining areas according to a thorough, written schedule.			F0812			
F0814 SS = F	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:			F0814			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0814 SS = F	Continued from page 2 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 and failing to ensure the trash bags filled with dietary and nursing trash were kept in an enclosure. Findings included: - During an initial tour of the kitchen on 08/03/2026 at 07:42, the following concerns were identified: 1. One of two dumpsters had the cover open. There were random pieces of trash littering the ground around the dumpster. 2. On 08/05/2026 at 07:45 AM, two of the two dumpsters were empty. There were 14 bags of trash containing dietary and nursing trash stacked next to one of the empty dumpsters. On 08/05/2026 at 07:56 AM, Administrative Staff A stated the sanitation company had not picked up the garbage on 08/04/2026, as planned but had picked up the garbage in the early morning of 08/05/2026. Administrative Staff A confirmed the bags of garbage had not been placed into the empty dumpsters and were stacked on the ground next to the dumpster. The facility policy for "Garbage and Rubbish Disposal", dated 2020, included: Garbage and rubbish will be disposed of to ensure a clean and sanitary kitchen that does not encourage insects or rodents. All outside dumpsters will be maintained in clean and sanitary condition.	F0814					
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology,	F0882					

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0882 SS = F	Continued from page 3 epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure the staff person designated as the Infection Preventionist (IP), who was responsible for the facility's Infection Prevention and Control Program (IPCP), was certified and had completed the specialized training in infection prevention and control Findings included: - On 08/04/2026 at 08:45 AM, Administrative Nurse D, upon request, was unable to provide evidence of certification for the facility's IP. On 08/04/2026 at 08:57 AM, Administrative Nurse D stated that she took over the IP position in December 2025 and that she had acquired her IP certification at another facility and did not have a copy of it. She stated that she had been unable to obtain it. The facility's policy "Infection Preventionist," dated 07/07/2026, documented the facility would employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program. The facility would designate a qualified individual as Infection Preventionist (IP) whose primary role was to coordinate and to be actively accountable for the facility's infection prevention and control program, including the antibiotic stewardship program. The IP must have obtained specialized IP certification beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate of completion or equivalent documentation.	F0882					
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F0584					

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0584 SS = E	Continued from page 5 Findings include: - Observed on 08/03/2026 at 07:47 AM, the ERU lounge area, across the hall from the shower room and by the exit to the smoking area, had three paper towels on the floor next to the sink, and the faucet was turned on. There was an empty medicine cup on the floor. There was an empty cup, unfolded gait belt, and a clock that had a loose battery on it, sitting on the table that was under the television. There was food debris on the floor next to a recliner, no trash bag in the trash can, and a dirty cup laid upside down on the counter next to the sink, the ice machine had a visible substance on it, and there was brown debris on the drain tray. There were two plastic cups stacked together with a visibly dirty coffee cup sitting next to the ice machine on the counter. The counter, under the ice machine, was visibly dirty with white debris. There was an unfolded gait belt on the table under the television and a clock with the battery laying on it on the table. Observed on 08/03/2026 at 02:34 PM, the ERU lounge area had a dirty coffee cup and dirty plastic cup sitting next to the ice dispenser machine on the counter. Observed on 08/04/2026 at 07:55 AM, the ERU lounge area had an empty medicine cup on the floor in front of the sink next to the trash can along with a wrapper and a piece of paper towel sitting on the floor. There was a dirty cup sitting on the table under the television and the ice machine was visibly dirty and a dirty cup sat next to sink on the counter. On 08/05/2026 at 09:32 AM, Certified Nurse Aide (CNA) P stated that she did not know who was responsible for cleaning the ERU lounge area and ice machine. On 08/05/2026 at 09:36 AM, Licensed Nurse (LN) H stated that there was a third-party contractor that cleaned the ice machine in the ERU lounge area and staff were to pick up the trash and dishes. On 08/05/2026 12:36 PM, Administrative Nurse D stated that a third-party contractor came semiannually and cleaned the ice machine in the ERU lounge area. She stated that she had discussed with staff that they were to check the ERU lounge area for trash and debris. The facility policy "Safe and Homelike Environment," dated 07/15/2026, documented in accordance with residents' rights, the facility would provide a safe, clean, comfortable and homelike environment,			F0584			

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F0584 SS = E	Continued from page 6 allowing the resident to use his or her personal belongings to the extent possible.	F0584					
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure an environment free from accident hazards when staff failed to secure disinfectant chemicals in a locked area and out of the reach of the 10 cognitively impaired, independently mobile residents. Findings included: - During the initial tour of the facility's Memory Unit on 08/03/2026 at 08:10 AM, an unlocked cabinet over the dining counter had an unmarked bottle with brown liquid, a bottle of rapid cleaner disinfectant, and two small bottles of peri care wash. On 08/03/2026 at 08:00 AM, Certified Medication Aide (CMA) stated chemicals should be locked, and it was every staff's responsibility to ensure chemicals were in a locked cabinet. On 08/03/2026 at 08:10 AM, Licensed Nurse (LN) G stated that chemicals should be locked in a cabinet, or placed in the dirty laundry room, which was locked. On 08/05/2026 at 12:33 PM, Administrative Nurse D stated chemicals should be in a locked cabinet, or behind a locked door. She stated all bottles should be labeled with contents. The facility's "Accidents and Supervision" policy documented the resident's environment would remain as free of accident hazards as possible. Each	F0689					

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F0689 SS = E	Continued from page 7 resident would receive adequate supervision and assistive devices to prevent accidents.	F0689					
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	F0636					

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F0636 SS = D	Continued from page 8 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 comprehensive Minimum Data Set Assessment (MDS) for two Residents (R)67, regarding discharge and R10, regarding nutrition. Findings included: - 1. R67's Electronic Medical Record (EMR) recorded a "Significant Change Minimum Data Set" (MDS), dated 06/05/26, with the "Activity Care Area Assessment" (CAA), dated 06/05/26, triggered but lacked an analysis of findings. 2. R10's EMR recorded a "Significant Change Minimum Data Set (MDS)" dated 05/01/2026, with the "Nutritional Status" CAA dated 05/06/2026 triggered but lacked analysis of findings. On 08/05/26 at 11:15 AM, Administrative Nurse D confirmed the activity CAA on the significant change MDS for R67, triggered but lacked an analysis of findings. On 08/04/26 at 11:30 AM, Administrative Nurse E			F0636			

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F0636 SS = D	Continued from page 9 stated it was the expectation for triggered CAAs to include an analysis of findings. Administrative Nurse E confirmed the "Nutritional Status" CAA on Significant change MDS dated 05/01/2026 lacked analysis. The facility policy for "MDS", revised 09/29/25, included: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary (ID) care plan.			F0636			
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:			F0641			

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F0641 SS = D	Continued from page 10 Based on observation, interview, and record review, the facility failed to accurately complete the "Minimum Data Set" (MDS) for two residents: Resident (R)118, regarding discharge location, and R10, regarding the use of continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). Findings included: - 1. R118's Electronic Medical Record (EMR) recorded an MDS dated 07/13/2026, which recorded R118 discharged, with return anticipated, to Home/Community, on 07/13/2026. R118's EMR under the "Prog Notes" tab, 07/13/2026, documented R118 admitted to the hospital. 2. R10's EMR recorded a "Significant Change MDS" dated 05/01/2026, which lacked documentation of the use of a CPAP during the observation period. R10's EMR under the "Orders" tab revealed the following physician orders: Non-invasive ventilator (NIV) settings: Intelligent Volume-Assured Pressure Support with Auto EPAP (iVAPS-AE), maximum 25 centimeter (cm), minimum EPAP 5 cm, maximum expiratory positive airway pressure (EPAP) 15 cm, minimum pressure support (PS) 5 cm, maximum PS 15 cm, Vt 500 milliliter (ml), rate-auto dated 03/06/2026. On 08/04/26 at 11:30 AM, Administrative Nurse E stated the MDS dated 07/13/2026, for R118 was inaccurate as R118 discharged from the facility to the hospital and did not discharge to her Home or the Community. Administrative Nurse E stated it was the expectation for the MDS to be completed accurately. Administrative Nurse E stated R10's CPAP should have been marked yes related to his usage of the CPAP in the facility. The facility policy for "MDS", revised 09/29/25, included: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary (ID) care plan.			F0641			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)			F0677			

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F0677 SS = D	Continued from page 11 §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, interview, and record review, the facility failed to provide the necessary activities of daily living (ADL) services for Resident (R)8, who did not receive adequate assistance with personal hygiene. Findings included: - Review of the Electronic Health Record (EHR) revealed R8's diagnoses included subarachnoid hemorrhage (bleeding in the space just outside of the brain), lack of coordination, contracture of muscle of multiple sites to lower body (abnormal permanent fixation of a joint or muscle), quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and dementia (a progressive mental disorder characterized by failing memory and confusion). R8's "Annual Minimum Data Set (MDS)," dated 10/13/2025, documented a Brief Interview for Mental Status (BIMS) score of eight indicating moderate cognitive impairment. He required a wheelchair for mobility; he required set-up/clean-up assistance for eating and was dependent on staff for bathing and all other ADLs. The "Functional Abilities Care Area Assessment (CAA)," dated 10/13/2025, documented R8 was dependent on staff for transfers to the shower and with personal hygiene. The "Urinary Incontinence and Indwelling Catheter CAA", dated 10/13/2025, noted that R8 was dependent on staff for toileting hygiene and was incontinent of urine. R8's "Quarterly MDS", dated 07/15/2026, documented a BIMS score of three indicating severe cognitive impairment. He required a wheelchair for mobility; he required set-up/clean-up assistance for eating and was dependent on staff for bathing and all other ADLs. R8's "Care Plan" dated 10/18/2023, instructed staff to provide substantial maximal assistance with oral			F0677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0677 SS = D	Continued from page 12 hygiene, supervision with set-up assistance for eating, and he was dependent on staff for toileting hygiene, upper body dressing and to shower/bathe. Staff was instructed to provide R8, who was dependent on staff to shower and bathe, with washcloths and soapy water for sponge bathing if bathing was refused. R8's EHR, under the bathing "Tasks" showed R8 received bathing eight times between 07/06/2026 and 08/04/2026. There were three documented bathing refusals in July 2026. The task did not show if the task performed was a bath, a shower or a bed bath. R8's EHR lacked documentation that R8 had refused to have his hair washed, face cleaned or clothes changed during the survey and observation dates below. Observation on 08/03/2026 at 09:22 AM, revealed R8 sat in his wheelchair at a table in the dining room. R8's hair was disheveled and uncombed. The hair looked greasy and had various sized pieces of debris throughout his shoulder length hair. R8 had a beard and mustache from his upper lip to just below his chin that had small to medium pieces of debris throughout his beard and small crumbly material around his mouth and lips. Observation on 08/04/2026 at 07:51 AM, revealed R8 sat at a table in the dining room eating his breakfast. His shirt had dried food stains to the right sleeve of his shirt that were reddish in color. His hair had large pieces of white debris and flakes throughout his hair. His hair looked greasy, disheveled, and uncombed. Observation on 08/04/2026 at 01:20 PM, revealed R8 was in his room in a wheelchair receiving wound care from Licensed Nurse H. R8's pants were wet in the front groin-area. His hair looked unkempt, matted, uncombed, oily and greasy. Observation on 08/05/2026 at 08:23 AM, revealed R8 was in his bed watching television. A tray with his morning meal was on table at bedside. His hair looked unkempt, disheveled, oily, and he had small to medium white debris throughout his hair, On 08/04/2026 at 08:42 AM, R8 reported that he had only been allowed one shower since admission and was told by staff he would get a shower two weeks ago but never did. He stated that he had requested showers but did not get them and said he had to give himself bed baths.			F0677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0677 SS = D	Continued from page 13 On 08/05/2026 at 10:43 AM, Certified Nurse Aide (CNA) O reported that R8 does not go into the shower. CNA O said staff gives R8 a bed bath, and during his bed bath staff used washcloths with some soap on them for his hair. On 08/05/2026 at 10:49 AM, Licensed Nurse (LN) H reported that he was unsure if staff cleaned R8's hair well when he was bathed. LN H reported R8 only received a shower 25% of the time and received a bed bath the other 75% of the time. LN H stated R8 was dependent on staff to transfer him to the shower with a mechanical lift which made it difficult when staff transferred him to the shower chair. On 08/05/2025 at 01:30 PM, Administrative Nurse D stated that R8 was dependent on staff and needed to be transferred using a mechanical lift. Administrative Nurse D stated it was her expectation that R8 received a bed bath, staff should use the available shower caps that were designed to wash/shampoo hair. Administrative Nurse D stated staff would be educated on how the shower caps were to be used and would use them going forward. The facility policy "Activities of Daily Living" dated 12/01/2025, documented that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			F0677			
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to provide an ongoing program of activities designed to meet the interests and well-being of Resident (R)11 and R67.			F0679			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0679 SS = D	Continued from page 14 Findings included: - 1. R11's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R11's "Significant Change Minimum Data Set" (MDS), dated 04/01/2026, documented the staff assessment for cognition revealed severe cognitive impairment. R11's preferences for activities included listening to music, being around animals such as pets, spending time outdoors, and participating in her favorite activities. She was dependent on staff for locomotion on the unit in her wheelchair. R11's "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 04/01/2026, documented staff should ask her yes/no questions. R11's "Quarterly MDS," dated 07/02/2026, documented the staff assessment for cognition revealed severe cognitive impairment. She was dependent on staff for locomotion on the unit in her wheelchair. R11's "Care Plan" for activities, revised 07/02/2026, instructed staff the resident enjoyed listening to music, watching movies, visiting with her family, and resting in her recliner. On 08/03/2026 at 08:37 AM, R11 sat in her specialized wheelchair at the dining table with peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 07:16 AM, R11 sat in her specialized wheelchair at the dining table with peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 09:59 AM, R11 sat in her specialized wheelchair at the dining table with peers. There was no activity or stimulation occurring at that time. R11 called out to several staff on several occasions with no response.			F0679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0679 SS = D	Continued from page 15 On 08/04/2026 at 12:22 PM, Certified Nurse Aide (CNA) M stated the resident did not participate in activities because she had dementia. On 08/04/2026 at 12:24 PM, CNA N stated R11 could not participate in activities due to her cognition; the resident would sit and people watch. On 08/04/2026 at 01:12 PM, Activity Staff Z stated there were multiple activities for residents with cognitive loss to do while they sat at the dining room table. Activity Staff Z stated she would need to do education with staff to ensure the activities were brought out and used on a routine basis. On 08/05/2026 at 10:00 AM, Licensed Nurse (LN) I stated the resident rarely participated in activities due to her cognitive loss. 2. R67's EMR documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R67's "Significant Change MDS" dated 06/05/2026, documented the staff assessment for cognition revealed severe cognitive impairment. R67's preferences for activities included listening to music, being around animals such as pets, spending time outdoors, and participating in her favorite activities. She was dependent on staff for locomotion in her wheelchair. R67's "Activity CAA" dated 06/05/2026, triggered but lacked an analysis of findings. R67's "Cognitive Loss/Dementia CAA," dated 06/05/2026, documented R67 had dementia. R67's "Care Plan" for activities, revised 06/18/2026, instructed staff it was important for her to have the opportunity to engage in daily routines and activities. She enjoyed visiting with her family, going outdoors, and looking out the window. On 08/03/2026 at 08:37 AM, R67 sat in her wheelchair at the dining table with her peers. There was no activity or stimulation occurring at that time.			F0679			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0679 SS = D	Continued from page 16 On 08/04/2026 at 07:16 AM, R67 sat in her wheelchair at the dining table with her peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 09:59 AM, R67 sat in her wheelchair at the dining table with her peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 12:22 PM, Certified Nurse Aide (CNA) M stated the resident did not participate in activities because she had dementia. On 08/04/2026 at 12:24 PM, CNA N stated R67 could not participate in activities due to her cognition. The resident would sit and people watch. On 08/04/2026 at 01:12 PM, Activity Staff Z stated there were multiple activities for residents with cognitive loss to do while they sat at the dining room table. Activity Staff Z stated she would need to do education with staff to ensure the activities were brought out and used on a routine basis. On 08/05/2026 at 10:00 AM, Licensed Nurse (LN) I stated the resident rarely participated in activities due to her cognitive loss. On 08/05/2026 at 12:33 PM, Administrative Nurse D stated it was the expectation for the residents with cognitive loss to have activities they enjoy. The facility policy for "Activities", revised 01/07/26, included: It is the policy of the facility to provide an ongoing program to support residents in their choice of activities.			F0679			
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			F0684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0684 SS = D	Continued from page 17 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate wheelchair positioning for Resident (R)11. Findings included: - R11's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R11's "Significant Change Minimum Data Set" (MDS), dated 04/01/2026, documented the staff assessment for cognition revealed severe cognitive impairment. She had limited range of motion (ROM) in her bilateral lower extremities (LE-legs). R11 was dependent on staff for locomotion in her wheelchair. R11's "Activity of Daily Living (ADL) Care Area Assessment" (CAA), dated 04/01/2026, did not trigger. R11's "Quarterly MDS," dated 07/02/2026, documented the staff assessment for cognition revealed severe cognitive impairment. She had limited ROM in her bilateral LEs and was dependent on staff for locomotion in her wheelchair. R11's "Care Plan", revised 07/02/2026, instructed staff she was dependent on staff for locomotion in her wheelchair. On 08/03/2026 at 08:37 AM, R11 sat in her wheelchair at the dining room table. Her feet hovered several inches above the footrest of the wheelchair. On 08/04/2026 at 07:16 AM, R11 sat in her wheelchair at the dining room table. Her feet hovered several inches above the footrest of the wheelchair. On 08/04/2026 at 09:59 AM, R11 continued to sit in her wheelchair at the dining table with her feet	F0684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0684 SS = D	Continued from page 18 hovering several inches above the footrest of the wheelchair. On 08/04/2026 at 12:22 PM, Certified Nurse Aide (CNA) M confirmed R11's feet did not reach the footrests of her wheelchair. On 08/04/2026 at 12:24 PM, CNA N stated R11's feet did not reach the footrests of the wheelchair. CNA N stated the footrest of the wheelchair needed to be adjusted to fit R11 better. On 08/05/2026 at 12:33 PM, Administrative Nurse D stated R11's footrest needed to be adjusted to better fit the resident and support her feet. The facility policy for "Use of Assistive Devices", revised 01/27/2026, included: The use of assistive devices will be based on the resident's needs, as indicated.			F0684			
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure Resident (R) 10's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask and oxygen tubing was stored in a sanitary manner to prevent contamination and respiratory infections. Findings included: - R10's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of diabetes			F0695			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0695 SS = D	Continued from page 19 mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dependent on dialysis (a procedure where impurities or wastes are removed from the blood), dependent on supplemental oxygen. The "Significant Change Minimum Data Set (MDS)" dated 05/01/2026 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS lacked documentation R10 was provided with his CPAP during the observation period. R10's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)", dated 05/06/2026, documented staff would assist R10 with activities of daily living (ADLs) as needed and encourage his participation with ADLs. R10's "Care Plan" documented the following interventions: 04/24/2026 – Staff would change oxygen tubing and rinse oxygen concentrator filter weekly. Staff would check oxygen saturation as ordered, see the treatment administration record. Staff would monitor changes in oxygenation status and keep the physician informed. Staff would administer R10's oxygen as ordered, see the treatment administration record. R10's EMR under the "Orders" tab revealed the following physician orders: Non-invasive ventilator (NIV) settings: Intelligent Volume-Assured Pressure Support with Auto EPAP (iVAPS-AE), maximum 25 centimeters (cm), minimum EPAP 5 cm, maximum expiratory positive airway pressure (EPAP) 15 cm, minimum pressure support (PS) 5 cm, maximum PS 15 cm, Vt 500 milliliter (ml), rate-auto dated 03/06/2026. Oxygen 3 liters per minute (LPM) continuous to keep oxygen saturation greater (>) than 90%, every shift for chronic respiratory failure dated 03/06/2026. Assist R10 with putting on NIV mask every night (Turn on machine, put mask on, and hit Start button on screen). Wake him to put on mask, even if he			F0695			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0695 SS = D	Continued from page 20 was already asleep. Make sure oxygen is set at 3LPM and connected to the NIV dated 03/06/2026. Assist R10 with taking the NIV mask off in AM (Take off mask and press and hold power button to turn off machine). Make sure to put oxygen on at 3LPM via nasal cannula, for obstructive sleep apnea (OSA) dated 03/06/2026. On 08/03/2026 at 09:45 AM, R10's NIV mask lay directly on the bedside table next to the machine, not in a container. On 08/04/2026 at 07:42 AM, R10 lay asleep on his bed with lights turned off. The head of his bed was elevated, and his oxygen was on. On 08/05/2026 at 10:26 AM, R10's oxygen tubing was wrapped together and placed under the handle of the oxygen concentrated machine, not in a container. On 08/05/2026 at 10:20 AM PM, Certified Nurse Aide (CNA) MM stated she would transfer the oxygen tubing from the concentrator to the portable oxygen tank after getting R10 up for the day. CNA MM stated she would then place the oxygen tubing inside the concentrator handle. On 08/05/2026 at 10:26 AM, Licensed Nurse (LN) I stated R10's CPAP mask and oxygen tubing should be stored in a bag when not in use. On 08/05/2016 at 12:30 PM, Administrative Nurse D stated she expected R10's respiratory equipment to be cleaned and changed as ordered. Administrative Nurse D stated she expected the respiratory equipment stored in the bag that was dated. The facility's "Oxygen Administration" policy dated 05/21/2026 documented oxygen was administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.			F0695			
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the			F0698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0698 SS = D	Continued from page 21 residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to complete and document a post hemodialysis (a procedure where impurities or wastes are removed from the blood) assessment for Resident (R) 10. Findings included: - R10's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dependent on dialysis (a procedure where impurities or wastes are removed from the blood), dependent on supplemental oxygen. The "Significant Change Minimum Data Set (MDS)" dated 05/01/2026 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R10 had received dialysis during the observation period. R10's "Nutritional Status Care Area Assessment (CAA)", dated 05/06/2026 lacked analysis. R10's "Care Plan," documented the following interventions: 02/26/2026 – Staff would encourage R10 to go to scheduled dialysis appointments. R10's dialysis days were on Monday, Wednesday, and Friday at 11:30 AM. Staff would send a snack meal with R10 if at dialysis during a meal. Staff would monitor his shunt site for signs and symptoms of infection, bleeding, or edema. Staff would not take blood pressure in the arm that has a shunt. Staff would obtain dry weights prior to dialysis treatment. Staff would weigh daily and notify physician if gain			F0698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0698 SS = D	Continued from page 22 or loss (blank) in one day or (blank) gain or loss in a week. (Specify). TR10's EMR under the "Orders" tab revealed the following physician orders: Dialysis on Monday, Wednesday, and Friday. Have R10 ready by 10:30 AM for dialysis dated 03/18/2026. The physician order lacked location of the dialysis provider. Monitor arteriovenous (AV) fistula/graft site for signs or symptoms of infection, edema, and bleeding upon return from dialysis. Notify physician of any signs noted. If site has bleeding, apply pressure for 15 minutes and notify physician if bleeding does not stop every shift. Port site right upper chest dated 03/07/2026. Weigh every Monday, Wednesday, and Friday prior to dialysis for fluid management for dialysis dated 03/06/2026. Review of the "Dialysis Communication Form" provided by the facility from 05/01/2026 to 08/03/2026 revealed 41 dialysis communication sheets. No post dialysis documentation was completed on the following 25 dates 05/01/2026, 05/08/2026, 05/11/2026, 05/13/2026, 05/18/2026, 05/2026, 05/2026, 05/22/2026, 05/27/2027/2026, 05/29/2026, 06/01/2026, 06/2026, 06/2026, 06/15/2026, 06/17/2026, 07/01/2026, 07/03/2026, 07/06/2026, 07/17/2026, 07/20/2026, 07/22/25026, 07/24/2026, 07/27/2026, 07/31/2026, and 08/03/2026. On 08/04/2026 at 07:42 AM, R10 laid asleep on his bed with lights turned off. The head of his bed was elevated, and his oxygen was on. On 08/05/2026 at 10:20 AM, Certified Nurse Aide (CNA) MM stated she would assist R10 with dressing and obtain his vital signs and weight before leaving for dialysis. On 08/05/2026 at 10:26 AM, Licensed Nurse (LN) I stated he would obtain R10's vital signs prior to leaving for dialysis. LN I stated the dialysis communication book was sent along with R10 to dialysis. LN I stated R10 would be assessed upon his return from dialysis and it would be documented on the dialysis communication sheet. On 08/05/2016 at 12:30 PM, Administrative Nurse D stated she expected the charge nurse to complete an assessment for R10 post return from his dialysis			F0698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER SHAWNEE GARDENS HEALTHCARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6416 LONG STREET , SHAWNEE, Kansas, 66216			
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F0698 SS = D	Continued from page 23 appointment. Administrative Nurse D stated she expected the nurse to document the assessment on the dialysis communication sheet. The facility's "Hemodialysis" policy dated 11/25/2025 documented the facility would provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis.	F0698					
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F0849					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0849 SS = D	Continued from page 24 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.	F0849					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0849 SS = D	Continued from page 25 (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form.	F0849					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0849 SS = D	Continued from page 26 (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure collaboration with the hospice provider for Resident (R) 2. Findings included: - R2's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), dementia (a progressive mental disorder characterized by failing memory and confusion), and myasthenia gravis (an abnormal condition that causes muscles to tire and weaken easily). The "Quarterly Minimum Data Set (MDS)" dated 05/27/2026 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R2 had received hospice services			F0849			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0849 SS = D	Continued from page 27 during the observation R2's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)", dated 02/27/2026 documented staff would assist her with activities of daily living as needed. R2 would work with therapy services to assist in increasing her functional mobility. R2's "Care Plan" documented the following interventions: 02/16/2026- Staff would assess her pain, restlessness, agitation, constipation, and other symptoms of discomfort. Staff would administer medication as ordered and evaluate effectiveness. Staff would provide nonpharmacological approaches to aid in decreasing discomfort. Staff would notify hospice of significant changes, clinical complications needing plan of care change, need to transfer to emergency department or death. Staff would provide medications per hospice and physician orders, see medication administration record and treatment administration record. Staff would provide food and fluids as desired for physical and emotional comfort. The plan lacked the frequency of hospice staff visits and the care they would provide, as well as the medications and equipment to be provided by hospice. R2's EMR under the "Orders" tab revealed the following physician orders: Admit to hospice with a diagnosis of myasthenia gravis dated 02/13/2026. On 08/04/2026 at 07:45 AM, R2 sat in a wheelchair in her room and had self-propelled herself to the bathroom. On 08/05/2026 at 10:20 AM PM, Certified Nurse Aide (CNA) MM stated she was informed of which resident received hospice services from the nurse during report. CNA MM stated the information for the services provided by hospice was listed on the residents' personalized care plan. On 08/05/2026 at 10:26 AM, Licensed Nurse (LN) I			F0849			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175267		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
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F0849 SS = D	Continued from page 28 stated he communicated with hospice staff when they came to the facility to provide care. LN I stated the information of what services are provided by hospice should be listed on the resident's care plan. On 08/05/2016 at 12:30 PM, Administrative Nurse D stated she expected there to be collaboration of care and services provided by hospice and that collaboration should be listed on the resident's care plan. The facility's "Coordination of Hospice Services" policy dated 12/02/2025 documented when a resident chose to receive hospice care and services, the facility would coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.			F0849			
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.			F0732			

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F0732 SS = C	Continued from page 29 (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 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 record reviews and interviews, the facility failed to post the required staffing information when the posted nurse staffing sheet did not list the actual staff hours worked as required. Findings included: - Review of the posted staffing sheets from 02/02/2025 to 08/02/2026 revealed the facility was unable to provide the posted staffing documentation that contained all the actual hours worked. The sheets contained the number of staff and the scheduled hours but not the actual hours worked. On 08/05/2025 at 12:33 PM, Administrative Staff A stated the staff coordinator was the person who posted and filled out the forms daily. She stated Administrative Staff A created a posted staffing sheet specifically to ensure all required information was posted. On 08/05/2026 at 12:55 PM, Administrative Staff A stated he had designed a posted staffing sheet to ensure the sheet that was posted met all required criteria for the state. He stated he did have a lot of			F0732			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0732 SS = C	Continued from page 30 the actual staff hours worked, but they were not posted. Administrative Staff A stated on the log staff must sign their hours. He confirmed the log was in a binder in the lobby, but it was not posted. The facility's "Nurse Staffing Posting Information Policy" last revised on 02/02/2025 documented it was the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The information posted would be presented in a clear and readable format. The posted staffing would be placed in a prominent place readily accessible to residents, staff, and visitors.	F0732			