

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175123		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2026	
NAME OF PROVIDER OR SUPPLIER MERRIAM GARDENS HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9700 W 62ND ST , MERRIAM, Kansas, 66203			
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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 3110948, 3095009, 3073185, 3104107, 306414, 3092788, 3154975, 3172095 & 3038692. The census was 81. The sample included 20 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 ensure one of the five Certified Nurse's Aides (CNA) reviewed had yearly performance evaluations completed. Findings included: - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA N, hired 04/16/2024, had no yearly performance evaluation upon request. On 08/12/2026 at 09:10 AM, Administrative Nurse D stated the director of nursing was responsible for nursing staff's performance evaluations. He stated the facility had identified that the reviews were not all completed and had started a Performance Improvement Plan (PIP). The facility's "Evaluation Process" dated 08/27/2025 documented			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 It was the policy of the facility to review the work performance of employees with a formal written evaluation annually. At the time the evaluation is given, the facility may or may not make salary/wage adjustments. There was no guarantee that a salary/wage rate increase will be given automatically each year. Factors that would be considered in making decisions about salary/wage adjustments include, but are not limited to job performance, achieving preset goals, attendance record, adherence to workplace policies, etc.	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. Findings included: - During an initial tour of the kitchen on 08/10/2026 at 07:27 AM, the following areas of concern were noted:	F0812					

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F0812 SS = F	Continued from page 2 1. Two white, three-tiered plastic carts used to transfer clean dishes to and from the dishwashing area had food ground into the corners of each tire. 2. Six wire racks in the two-doored, reach-in refrigerator were missing several areas of the plastic protective coating. 3. The rubber seal around one of the doors of the two-door, reach-in refrigerator hung loosely beneath the door. 4. Three wire racks in the two-door, reach-in freezer had several areas of the plastic protective coating missing. 5. Six wire racks in the three-door, reach-in refrigerator had several areas of the plastic protective coating missing. On 08/12/2026 at 08:30 AM, Dietary Staff CC confirmed the noted areas needed replacement. The facility policy "Sanitation Inspection", revised 01/01/2026, included: It is the policy of the facility to ensure food service areas are clean and sanitary.	F0812					
F0947 SS = F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F0947					

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F0947 SS = F	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure five of the five Certified Nurse Aide (CNA) staff reviewed had the required 12 hours of in-service education. Findings included: - Review of the information facility's in-service records revealed the following CNAs were employed with the facility for more than 12 months: CNA O, hired on 12/28/2023, had not completed the required in-services in the past 12 months. CNA N, hired on 04/16/2024, had not completed the required in-services in the past 12 months. CNA P, hired on 11/15/2022, had not completed the required in-services in the past 12 months. On 08/12/2026 at 09:15 AM, Licensed Nurse (LN) K stated the facility did have online education. She stated the staff could do the in-services when there was downtime, or after their shift. On 08/12/2026 at 10:15 AM, Administrative Staff A stated human resources oversaw the staff's in-services. He stated in the last few weeks the facility was aware the facility and staff were falling short in this area and had started a Performance Improvement Plan (PIP) On 08/12/2025 at 11:46 AM, Administrative Nurse D stated the human resource facility department, she stated the facility had gotten computers for staff to do in-services. She stated the staff could do in-services in their downtime or after their shifts. The facility did not provide an in-service policy as requested on 08/12/2026.	F0947					
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F0759					

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F0759 SS = E	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a medication error rate below five percent. Twenty-five medication administrations were observed, with 5 errors identified, resulting in a medication error rate of 20 percent (%). Findings included: - Resident (R) 18's Electronic Health Record (EHR) documented the following orders: Levetiracetam oral solution 100 milligrams (mg)/milliliter (ml), give five ml via gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) two times a day. Oxybutynin chloride oral tablet five mg, give five mg by mouth two times a day. Acetaminophen 160 mg/five ml oral liquid, give 30 ml via G-tube three times a day. Carbidopa 25 mg/levodopa 100mg oral tablet, give one tablet via G-tube three times a day. Diltiazem HCl tablet 60 mg, give one tablet via G-tube four times a day. R18's EHR lacked orders for medications to be crushed and/or mixed. Observed on 08/11/2026 10:14 AM, Licensed Nurse (LN) H crushed R18's oral tablet medications and mixed them all into a cup with liquid medication. At 10.23 AM, LN H provided R18 with her crushed and mixed medications via her G-tube. On 08/11/2026 at 02:21 PM, LN H stated all oral medication tablets were crushed and mixed with R18's acetaminophen and levetiracetam oral suspensions. LN H verified that R18 lacked an order for her medications to be crushed and mixed. He confirmed there should have been an order to crush and combine the medications. On 08/12/2026 at 11:53 AM, Administrative Nurse D stated that when combining medications via a G-tube there should be an order in place. The facility charge nurse is to monitor orders for G-tube medication administration. Administration and Pharmacy should also perform monthly audits of			F0759			

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F0759 SS = E	Continued from page 5 G-tube medication administration orders.	F0759					
F0761 SS = E	The facility's policy "Medication Administration via Enteral Tube" dated 06/16/2026, documented it is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that medications were stored safely and securely as required. Findings included: - R6's Electronic Health Record (EHR) documented diagnoses that included altered mental status (state of awareness that was different from the normal awareness of a person) and blindness in both eyes.	F0761					

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F0761 SS = E	Continued from page 6 Observed on 08/11/2026 at 07:28 AM, A tube of Coloplast/Triad Wound Care prescription medication cream was left on R6's bedside table located next to R6's bed. The prescription treatment cream was not secured in the treatment cart. Observed on 08/11/2026 at 11:07 AM, a medication cart on 400 hall was unsupervised with a card of celecoxib (nonsteroidal anti-inflammatory drug used to treat mild to moderate pain and help relieve symptoms of arthritis) 100 milligrams with 23 tablets in the card. The card was face down on the medication cart. Licensed Nurse (LN) J walked out of R20's room and returned to the medication cart. Observed on 08/12/2026 at 07:37 AM, a treatment cart on Hall 300 was unlocked and unattended. It contained resident identified medication that included cream-ointment in the top drawer and the third drawer and glucose testing supplies in the second drawer. During an interview on 08/11/2026 at 07:36, Certified Nurse Aid (CNA) M stated the prescription medication cream should not have been left in R6's room. During an interview on 08/11/2026 at 07:49 AM, LN H stated the prescription medication cream should never be left in the room on a table at bedside. The prescription medication should have been in the locked treatment cart. During an interview on 08/11/2026 at 11:07 AM, LN J stated that medication was never supposed to be left unattended; it should always be kept locked in the medication cart or locked in the medication storage room. During an interview on 08/11/2026 at 11:13 AM, Administrative Staff B stated that medication should never be left unattended. Medication should be placed in the medication carts and locked before walking away from the cart. If it was to be removed from the cart, then it was to be placed in the locked medication storage room. During an interview on 08/12/2026 at 07:41 AM, LN G stated that the treatment cart was supposed to			F0761			

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F0761 SS = E	Continued from page 7 always be locked when unattended. She had not checked it before starting her shift to see if it was locked. During an interview on 08/12/2026 at 11:45 AM, Administrative Nurse D stated that medication should never be left unattended. It should be kept in a locked medication cart or locked medication storage room. Medication carts should always be locked before staff were to walk away from them. Administrative Nurse D stated that treatment carts should never be left unlocked and unattended. During an interview on 08/12/2026 at 11:46 AM, Administrative Nurse D stated the expectation is that any prescription medication should not have been left in a room on a bedside table. The treatment cart is where all prescription medications should have been stored as soon as a treatment had been provided. The facility's "Medication Storage" policy dated 03/31/2026 documented it was the policy of that facility to ensure all medications housed on their premises would be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. All drugs and biologicals would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.	F0761					
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880					

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F0880 SS = E	Continued from page 8 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880					

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F0880 SS = E	Continued from page 9 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews, the facility failed to implement adequate infection control practices when staff failed to use a barrier before laying a glucose monitor on the dining room table, failed to store Resident (R)86'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 in a sanitary manner and failed to transport linens in a sanitary manner. Findings included: - On 08/10/2026 at 07:56 AM observation revealed a clear bag of trash laid on the floor in R14's room. On 08/10/2026 at 7:57 AM Licensed Nurse (LN)I laid the glucose monitor on the dining room table without a sanitary barrier. LN I picked up the glucose monitor and pushed R47 to the hallway to check his blood sugar using the monitor. On 08/11/2026 at 7:52 AM R86's CPAP mask lay on her bedside table without a container. R86 stated she was able to take the CPAP mask off by herself. She stated she did not have a bag for her CPAP mask. R86 stated she could not put the mask into a container or a bag by herself. On 08/12/2026 at 08:15 AM observation on the 200 hall revealed a clear bag of trash that contained a soiled incontinence brief lay in the hallway, in front of a resident room. On 08/12/2026 at 08:17 AM Certified Nurse's Aide (CNA)P carried a green bed spread, and a stack of sheets down the hall, holding the linens next to her body and in contact with her uniform. On 08/12/2026 at 9:00 AM CNA Q stated she was unsure how a CPAP mask should be stored. She stated she had seen some residents with containers. CNA Q stated if the mask had a container, it should be placed back in the container. She stated trash should never be left on the floor and it was all staff's responsibility to ensure there was no trash			F0880			

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F0880 SS = E	Continued from page 10 on the floor. CNA Q stated linens should be in a covered cart or carried away from the staff's uniforms. On 08/12/2026 at 9:10 AM LN L stated linens should be carried away from the staff's uniforms. She stated CPAP masks normally have their own containers and the mask should be placed into the CPAP mask container. LN L stated trash bags should never be placed on the floor, and any staff member should immediately pick the bags up and place them in the trash containers. The facility's "Oxygen Administration" 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. The facility's "Handling Soiled Linen" 07/07/2026 documented it is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. This policy pertains to soiled linen. The facility's "Infection Prevention and Control Program" undated This facility had established and maintained an infection prevent and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection diseases and infections as per accepted national standards and guidelines.			F0880			
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.			F0582			

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F0582 SS = D	Continued from page 11 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to provide the correct Center for Medicare and Medicaid (CMS) Form 10055, "Advanced Beneficiary Notice" (ABN), for Resident (R)33 and R96. Findings included: - The Medicare ABN form informed the beneficiaries Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included options for the beneficiary to receive specified services listed and			F0582			

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F0582 SS = D	Continued from page 12 bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for payment, but I can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment of services. (3) I do not want the listed services. The facility's Medicare ABN form staff provided to R33 (or their representative) was form CMS-R-131 for the last Medicare Part A covered day of 07/22/2026. The facility's Medicare ABN form staff provided to R96 (or their representative) was form CMS-R-131 for the last Medicare Part A covered day of 05/28/2026. On 08/11/2026 at 09:27 AM, Social Service X stated the CMS-R-131 was provided to her approximately four months prior by the therapy director; and she was instructed to use that form. On 08/11/2026 at 09:33 AM, Administrative Staff A expected the facility to review to make sure they are using the right form. The facility's "Advance Beneficiary Notices" policy, dated J05/27/2026, documented the current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055.	F0582			
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and	F0583			

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F0583 SS = D	Continued from page 13 meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy to Residents (R)16 and R 65 while the residents were in their rooms. Findings included: - 1. R16's electronic medical record (EMR) documented a diagnosis of dementia. R16's "Annual Minimum Data Set" (MDS), dated 05/29/2026, documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. He required partial to moderate staff assistance to turn left and right while in bed. R16's "Activity of Daily Living (ADL)/Functional Capacity Care Area Assessment" (CAA), dated 05/29/2026, did not trigger. R16's "Quarterly MDS," dated 03/02/2026, documented a BIMS score of zero, which indicated severe cognitive impairment. He required partial to moderate staff assistance to turn left and right while	F0583					

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F0583 SS = D	Continued from page 14 in bed. R16's "Care Plan", revised 05/18/2026, instructed staff that he required assistance with ADLs related to dementia and weakness. R16's EMR from 07/14/2026 through 08/10/2026 (30 days) documented he was dependent on staff to turn left and right while in bed. On 08/11/2026 at 02:00 PM, R16 rested in his bed on his right side with his back side to the room's open door, and the privacy curtain was not drawn. R16's bare legs and brief were visible to other residents and staff who passed his room. 2. R65's EMR documented a diagnosis of obesity. R65's "Admission MDS," dated 03/03/2026, documented a BIMS score of 12, which indicated moderately impaired cognition. He required substantial to maximum staff assistance to turn left to right while in bed. R65's "ADL CAA," dated 03/03/2026, documented he had decreased functional abilities due to impaired strength and mobility. R65's "Quarterly MDS," dated 06/03/2026, documented a BIMS score of 12, which indicated moderately impaired cognition. He required supervision and touching assistance from staff to turn from left to right while in bed. R65's "Care Plan", revised 05/27/2026, instructed staff that he required assistance with ADLs. R65's EMR from 07/14/2026 through 08/10/2026 (30 days) documented that he required substantial to dependent assistance from staff to turn from left to right while in bed. On 08/10/2026 at 08:05 AM, an unidentified staff exited the resident's room. When the staff opened the door to R65's room, he lay in his bed in his incontinence brief and was exposed. On 08/12/2026 at 09:05 AM, Licensed Nurse (LN) I stated staff should have kept residents' doors closed or the privacy curtain drawn to allow the residents privacy while they were in their beds. On 08/12/2026 at 11:46 AM, Administrative Nurse D stated it was expected that staff would ensure residents' privacy when they entered or exited the residents' rooms.			F0583			

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F0583 SS = D	Continued from page 15	F0583					
F0628 SS = D	The facility policy "Promoting/Maintaining Resident Dignity", revised 01/01/2026, included: Staff shall maintain resident's privacy at all times. Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with	F0628					

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F0628 SS = D	Continued from page 16 paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F0628					

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F0628 SS = D	Continued from page 17 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;			F0628			

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F0628 SS = D	Continued from page 18 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure Resident (R)6 and their representatives received a written notification of transfer that included a statement of the residents' rights, the transfer location, reason for the transfer, and the state ombudsman information, as soon as practicable upon their transfer to the hospital. Additionally, the facility failed to notify the office of the Long-Term Care Ombudsman (LTCO) of the transfers.			F0628			

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F0628 SS = D	Continued from page 19 Findings included: - R6's Electronic Medical Record (EMR) recorded a "Discharge Minimum Data Set" (MDS)" dated 05/24/2026, which documented an unplanned discharge to an acute hospital with a return anticipated. R6's "Licensed Nurse Progress Note" dated 05/24/2026 documented R6 was sent to the hospital by ambulance on 05/24/2026 at 10:36 AM. R6's clinical record lacked evidence that a written notification of transfer was provided to R6 or their representative. Upon request, the facility was unable to provide evidence of the written notification. On 08/12/2026 at 10:28 AM, Administrative Staff A stated the facility had not provided R6 (or their legal representatives) with written notice of their transfer to the hospital, and confirmed the LTCO was not notified. Administrative Staff A stated the social service department was responsible for the notification. The facility transfers and discharge policy dated 07/14/2025 documented the facility's transfer/discharge notice will be provided to the resident and resident representative in a language and manner in which they can understand. The facility will maintain evidence that the notice was sent to the Ombudsman.			F0628			
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment in the required 92-days for Resident (R)42 and R68. Findings included: - Review of R42's Electronic Medical Record (EMR) revealed she had a "Quarterly MDS" dated			F0638			

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F0638 SS = D	Continued from page 20 04/11/2026 with the next quarterly assessment reference date (ARD) set as 07/12/2026. The EMR indicated the MDS was "In Progress." Review of R68's EMR revealed he had a "Quarterly MDS" dated 04/09/2026 with the next quarterly ARD set as 07/10/2026. The EMR indicated the MDS was "In Progress." On 08/12/2026 at 10:15 AM, Administrative Nurse E stated she had overlooked R42 and R68's quarterly assessment. Administrative Nurse F stated she was currently working on completing the MDS. On 08/12/2026 at 11:50 AM, Administrative Nurse D stated Administrative Nurse F was responsible for ensuring each resident's MDS was completed as indicated. The facility's "MDS 3.0 Completion" policy dated 01/01/2026 documented residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Quarterly assessments are completed using the ARD, which is not greater than 92 days from the most recent prior quarterly or comprehensive assessment.			F0638			
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:			F0676			

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F0676 SS = D	Continued from page 21 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to provide care and services to prevent further decline in range of motion when staff failed to provide Resident (R)13's adaptive eating utensils and further failed to have a consistent method of communication for R9, whose primary language was not English. Findings Included: - 1. R13's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right non-dominant side, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), contracture of the left upper arm, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and need for assistance with personal care and feeding difficulties. The "Quarterly Minimum Data Set" (MDS) dated 06/06/2026 documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R13 had	F0676			

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F0676 SS = D	Continued from page 22 an impairment on one side of his upper and lower body. The MDS documented R13 needed set up or clean up assistance with eating and needed a mechanically altered diet. R13's "Communication Care Area Assessment" (CAA) dated 06/06/2026 documented communication would be addressed in R13's plan of care. R13's CAA documented staff were to communicate in a calm and friendly manner and allow adequate time for R13 to make his needs known. The CAA documented staff were to monitor for any changes in R13's ability to communicate. R13's "Care Plan" documented the following: 06/24/2024-Staff were to assist R13 with meals. Staff were to encourage R13 to eat all meals in the dining room for increased staff observation. R13 was to have setup and clean up assistance with eating. 05/08/2025- R13 was to be served a mechanical soft diet. Staff was to educate R13 about what was compliant for his diet. 06/05/2026-R13 was to use adaptive equipment with eating, including a divided plate, utensils with thin black handles for increased grip, a five-millimeter (ml) Euchon (a cup that limits fluid) cup, and no straws. R13's EMR under "Orders" revealed the following physicians' orders: Regular general diet, ground mechanical soft texture. Regular thin consistency, with a flow controlled five ml Euchon cup for liquids, no straws. Alternate bites and drinks. Use utensils with thin black handles for all meals for increased grip. Mighty shakes with all meals. Divided plate and encouraged to eat in the dining room. R13's "Meal Ticket" revealed a diet of regular mechanical soft with thin liquids, a divided plate, black built-up utensils and no straw. On 08/10/2026 at 08:55 AM, R13 sat in his room in his wheelchair. R13's plate sat on his bedside table, the plate was covered with a warmer food cover, with regular silverware wrapped in a napkin. R13 had a divided plate and an Euchon cup with a dark brown liquid. R13 did not have the slim black handled built-up silverware.			F0676			

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NAME OF PROVIDER OR SUPPLIER MERRIAM GARDENS HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 9700 W 62ND ST , MERRIAM, Kansas, 66203			
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F0676 SS = D	Continued from page 23 On 08/10/2026 at 02:10 PM, R13 sat in his room in his wheelchair. R13 had a divided plate that was covered with a warmer food cover and an Euchon cup with a dark brown liquid. R13 had a regular fork and spoon wrapped in a napkin. R13 did not have the slim black handled silverware. On 08/11/2026 at 08:40 AM, PM R13 sat in his room in his wheelchair. R13 had a divided plate, that remained covered with a food cover warmer, and an Euchon cup with a dark brown liquid. R13 had a regular fork and spoon wrapped in a napkin. R13 did not have the slim black handled silverware. On 08/12/2026 at 09:00 AM, Certified Nurse's Aide (CNA)Q stated the dietary was to place the built-up silverware on R13's plate. She stated whoever passed his tray should uncover the tray, set it up, and ensure the built-up utensils were on his tray. On 08/12/2026 at 09:10 AM, Licensed Nurse (LN)K stated whoever passes R13's tray should ensure the built-up utensils were on his tray. She stated staff should make sure the tray was set up and ready for R13 to start eating. On 08/12/2026 at 09:57 AM, Dietary Staff CC stated the kitchen staff was to put R13's silverware on his tray, and ensure he had an Euchon cup. She stated each resident had a "Meal Ticket" that kitchen staff was to follow when setting up trays. On 08/12/2026 at 11:46 AM, Administrative Nurse D stated the staff should set up R13's tray and have it ready for him to start eating. She stated the dietary department had a ticket that states what diet and any special instructions each residents needed. Administrative Nurse D stated the staff member passing the tray should ensure each resident had what that needed before leaving the tray in a room. 2. R9s Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), dependence on renal dialysis (a procedure where impurities or wastes are removed from the blood), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The "Quarterly Minimum Data Set (MDS)" dated 07/16/2026 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R9's preferred language was Spanish.			F0676			

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F0676 SS = D	Continued from page 24 R9's "Communication Care Area Assessment (CAA)", dated 09/26/2025, documented she only spoke "broken English." Her native language was Spanish. She was able to communicate via an interpreter. R9's "Care Plan," documented the following interventions: 06/30/2024 – Her preferred language was Spanish. On 08/10/2026 at 08:30 AM, R9 laid on her bed in the lowest position. She indicated she was unable to communicate in English. Facility staff stated R9 had a translation app on her phone. R9 refused to allow surveyor to use her phone for communication. Staff stated there was a staff member that assisted R9 with communication with other staff to make her needs known. On 08/10/2026 at 09:45 AM, Certified Nurse Aide (CNA) P stated staff would use R9's cell phone and if she refused staff would download a translation app onto their phone. CNA P stated there was a staff member that would assist with communication, but she only worked on dayshift. On 08/12/2026 at 10:01 AM, Licensed nurse (LN) I stated there was staff member that would assist with communication with R9. LN I stated there was not a Spanish speaking staff on night shift. LN I stated the staff would use R9's phone or their phones for communication. LN I stated there was a phone number for translation but did not know where that number was written down. LN I stated she was not sure if that information was posted anywhere to assist with the ability to have private conversations with R9. On 08/12/2026 at 11:50 AM, Administrative Nurse D stated the staff would use R9's phone or staff would use their phones to assist with translation and communication in Spanish. Administrative Nurse D stated the facility did use the medical records staff and housekeepers to assist R9 with her communication in Spanish. Administrative Nurse D stated the facility did not have an interpreter phone to assist R9 with communication. Administrative Nurse D stated staff used the medical records staff to assist R9 with her private conversation. The facility's "Culturally Competent Care" policy dated 03/04/2026 documented It is the policy of this facility to provide culturally competent care in accordance with professional standards of practice.			F0676			

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F0676 SS = D	Continued from page 25 The facility has established an environment that treats each resident with respect and dignity as an individual. The facility supports and/or enhances residents' feelings of self-worth and encourages personal control over choices and cultural preferences.	F0676					
F0677 SS = D	The facility's "Activities of Daily Living (ADL)" policy dated 12/01/2025 documented the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration was unavoidable. 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, interview, and record review, the facility failed to provide appropriate activities of daily living (ADL) cares for two Residents (R)16 and R13, regarding bathing. Findings included: - 1. R16's electronic medical record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R16's "Annual Minimum Data Set" (MDS), dated 05/29/2026, documented a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. He was dependent on staff for bathing. R16's "Activity of Daily Living (ADL) Care Area Assessment" (CAA), dated 09/29/2026, did not trigger. R16's "Quarterly MDS," dated 03/02/2026, documented a BIMS score of zero, indicating severe cognitive impairment. He was dependent on staff for bathing.	F0677					

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F0677 SS = D	Continued from page 26 R16's "Care Plan", revised 05/18/2026, instructed staff R16 required staff assistance with ADLs related to dementia. R16's EMR from 07/13/2026 to 08/10/2026 (30 days), revealed he received showers on 07/13/2026, 07/23/2026, 07/27/2026 and 08/03/2026. No other bathing activities were documented. On 08/10/2026 at 01:58 PM, R16 sat in his wheelchair by the nurse's station. He had dirty, greasy hair. On 08/11/2026 at 08:40 AM, R16 sat in his wheelchair at the dining table. He had dirty, greasy hair. On 08/11/2026 at 11:00 AM, Certified Medication Aide (CMA) S stated R16 can be combative at times, so his showers are not always done twice weekly. On 08/11/2026 at 01:56 PM, Licensed Nurse (LN) I stated R16 becomes combative at times, so staff try to give him something to calm him down before bathing. LN, I confirmed the resident was not always bathed twice. On 08/12/2026 at 11:46 AM, Administrative Nurse D stated R16 required two staff to bathe him, so he does not always get two showers per week. - R13's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right non-dominant side, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), contracture of left upper arm, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and the need for assistance with personal care and	F0677					

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F0677 SS = D	Continued from page 27 feeding difficulties. The "Quarterly Minimum Data Set" (MDS) dated 06/06/2026 documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R13 had an impairment on one side of his upper and lower body. The MDS documented R13 needed set up or clean up assistance with oral hygiene, was dependent on staff for personal hygiene, and needed substantial/maximal staff assistance for bathing. R13's "Communication Care Area Assessment" (CAA) dated 06/06/2026 documented communication would be addressed in R13's plan of care. R13's CAA documented staff were to communicate in a calm and friendly manner and allow adequate time for R13 to make his needs known. The CAA documented staff were to monitor for any changes in R13's ability to communicate. R13's EMR under "Task" documented bathing/shower from (07/11/2026-08/12/2026). Bathing/shower completed on 07/15/2026, 07/18/2026, 07/22/2026, 07/29/2026, 08/04/2026, and 08/05/2026.(six times for the entire month reviewed. R13's EMR under "Task" documented one refusal for bathing on 08/08/2026. On 08/10/2026 at 08:55 AM, R13 sat in his room in his wheelchair. R13's hair was matted on the back of his head. R13 had a blue shirt on that had food or drink stains in the front. R13 had food crumbs in his beard. R13's fingernails had a brown substance under his nails on his right hand. On 08/11/2026 at 08:40 AM, R13 sat in his room in his wheelchair. R13's hair was matted on the back of his head. R13's fingernails had a brown substance under his nails on his right hand. On 08/12/2026 at 09:00 AM, Certified Nurses Aide (CNA) Q stated all CNAs were assigned bathing for their residents daily. She stated a bath sheet was filled out and turned in for each bath given. She stated if a resident refused bathing, she would report to the nurse for that resident. CNA Q stated the nurse would follow up with the resident before documenting a refusal. On 08/12/2026 at 09:10 AM, Licensed Nurse (LN) K stated bathing was assigned for different residents			F0677			

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F0677 SS = D	Continued from page 28 on each shift. She stated the CNAs on the assigned shifts would offer bathing. LN K stated if a resident refused bathing, the CNAs were to let the nurse know. LN K stated the nurse would document in a progress note any bathing refusal. On 08/12/2026 at 11:46 AM, Administrative Nurse D stated the CNAs offered bathing to residents assigned for their shift. She stated if a resident refused to bathe, the CNA would let the nurse know. She stated the nurse would talk to the resident and try to set bathing for a time that would work with the resident. Administrative Nurse D stated the nurse should document in the resident's progress note any refusals. The facility policy "Resident Showers", revised 01/01/2026, included: It is the practice of the facility to assist residents with bathing to maintain proper 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 record review, observation, and interviews, the facility failed to provide an ongoing program of activities designed to meet the interests and well-being of Resident (R) 16. Findings included: - R16's electronic medical record (EMR) documented a diagnosis of dementia. R16's "Annual Minimum Data Set" (MDS), dated 05/29/2026, documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe			F0679			

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F0679 SS = D	Continued from page 29 cognitive impairment. The MDS documented it was very important for him to have snacks between meals, listen to music, be around animals, such as pets, and to participate in his favorite activities. R16's "Activity Care Area Assessment" (CAA), dated 05/29/2026, did not trigger. R16's "Quarterly MDS," dated 03/02/2026, documented he had a BIMS score of zero, which indicated severe cognitive impairment. R16's "Care Plan", revised 05/18/2026, instructed staff that he required assistance to attend group activities and special events. R16's care plan informed staff that he enjoyed pet visits, snacks, and all music events. R16's EMR from 07/14/2026 through 08/10/2026 (30 days) documented that he was a passive participant in four activities. R16's EMR lacked further activity documentation. On 08/11/2026 at 01:12 PM, Activity Staff BB stated R16 was only able to participate passively in activities, and the facility had not provided one-to-one (1:1) activities. On 08/11/2026 at 01:23 PM, Certified Nurse Aide (CNA) Q stated R16 had not participated in activities due to his cognition. On 08/11/2026 at 01:56 PM, Licensed Nurse (LN) H stated R16 had not participated in activities. On 08/12/2026 at 11:46 AM, Administrative Nurse D stated R16 would have benefited with 1:1 activities since he was unable to actively participate in group activities due to his cognition. The facility policy "Activities", revised 01/01/2026, included: It is the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their preferences.			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			

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F0684 SS = D	Continued from page 30 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 provide appropriate wheelchair positioning for one Resident (R)16. Findings included: - R16's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R16's "Annual Minimum Data Set" (MDS), dated 05/29/2026, documented a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. He had functional limitation in range of motion (ROM) on one side of his upper and lower extremities (UE/LE). He was dependent on staff for locomotion in his wheelchair. R16's "Activity of Daily Living (ADL) Care Area Assessment" (CAA), dated 05/29/2026, did not trigger. R16's "Quarterly MDS," dated 03/02/2026, documented he had a BIMS score of zero. He had a functional limitation in ROM on one side of his UE and LEs and was dependent on staff for locomotion in his wheelchair. R16's "Care Plan" revised 05/18/2026, instructed staff that he had limited mobility due to weakness. On 08/10/2026 at 01:58 PM, R16 sat partially reclined in his wheelchair in the hallway. His right foot had fallen off the footrest, which caused his right leg to hang, unsupported, from the wheelchair. On 08/11/2026 at 09:09 AM, R16 sat partially reclined in his wheelchair in the hallway. His right foot had fallen off the footrest, which caused his right leg to hang, unsupported, from the wheelchair.			F0684			

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F0684 SS = D	Continued from page 31 On 08/11/2026 at 11:00 AM, Certified Medication Aide (CMA) S stated R16 was unable to keep his foot up on the footrest of the wheelchair. CMA stated when the resident's foot came off of the footrest, his right leg would hang from the side of the wheelchair. On 08/11/2026 at 01:56 PM, Licensed Nurse (LN) I confirmed R16's right leg hung from the side when his wheelchair was reclined. She stated R16 needed something to keep his leg in place while he was reclined in his wheelchair. On 08/12/2026 at 11:46 AM, Administrative Nurse D confirmed R16's leg would not stay positioned on the footrest while his wheelchair was reclined. The facility did not provide a policy regarding wheelchair positioning.			F0684			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure a fall intervention was implemented for Resident (R) 36 and fall intervention was in place for R40 to prevent further falls. Findings included: - 1. R36's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of unsteadiness on feet, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and dementia (a progressive mental disorder characterized by failing memory and			F0689			

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F0689 SS = D	Continued from page 32 confusion). The "Quarterly Minimum Data Set (MDS)" dated 07/17/2026 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R36 had at least one fall since her admission. R36's "Falls Care Area Assessment (CAA)", dated 01/28/2026, documented she had fallen one time and was at risk for further falls. R36's "Care Plan" documented the following interventions: 01/10/2025 – Staff would anticipate and meet her needs. Staff would ensure her call light was within reach and encourage her to use it for assistance as needed. Staff would ensure prompt response to all requests for assistance. Staff would ensure that she was wearing appropriate footwear when mobilizing in the wheelchair. Staff would follow the facility's fall protocol. Therapy would evaluate and treat as ordered or as needed. 02/11/2025 – Staff placed a Dycem (non-slip mat used for stabilization and gripping to prevent slipping) to her wheelchair. 02/24/2025 – Anti-roll back brakes repaired. 02/28/2025 – Staff would continue current interventions on the at-risk plan. Staff would monitor, document, or report as needed to the physician for any signs or symptoms of pain, bruises or changes of condition. Pharmacy consult would evaluate medications. Staff would provide activities that promoted exercise and strength building where possible. Staff would provide one-on-one activities if she was bedbound. 04/29/2025 - Equipment failure and a work order			F0689			

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F0689 SS = D	Continued from page 33 was placed. 03/13/2025 – Staff educated her on not using her head to hold the door open. 05/14/2025- Staff educated R36 on safety while sitting, not to lean forward in the chair. 10/07/25- Staff educated her on proper positioning when sitting in the wheelchair and lying on the bed. 12/08/2025 – Anti roll back brakes fixed by maintenance. Staff would check R36's range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) (specify number of times) daily. Staff would assess for any apparent acute injury and determine and address causative factors of the fall. 12/16/2025 – Staff was educated on proper blocking during transfers. 01/09/2026 – Her bed was moved against the wall, and removed the top sheet because she did not want to use the top sheet. 07/13/2026 – Staff provided re-education on the need to call for assistance with transfers. Staff would ensure non-skid footwear was in place. Staff would ensure her bedside table was within her reach. Staff reminded her to lock her wheelchair to prevent it from rolling backwards. 07/20/2026 – Staff placed grip strips halfway under her bed. R36's EMR under the "Progress Notes" tab revealed the following "Nurse's Note" dated 07/02/2026 at 04:01 PM documented R36 was found sitting on the floor in front of her bed. R36 had complained of lower back pain and left knee pain, staff had her assessed by the physician assistant. He found no injuries at the time of assessment. On 08/11/2026 at 08:13 AM, R36 laid on the edge of her bed asleep. Bed was in the lowest position, and nonskid strips on the floor next to the bed were slightly under the bed.			F0689			

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F0689 SS = D	Continued from page 34 2. R40's EMR from the "Diagnosis" tab documented diagnoses of repeated falls, dementia (a progressive mental disorder characterized by failing memory and confusion), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The "Quarterly MDS" dated 06/13/2026 documented a BIMS score of three, which indicated severely impaired cognition. The MDS documented R40 had at least one fall in the facility. R40's "Falls CAA" dated 03/16/2026 documented he had fallen prior to his admission to the facility. R40 had one non-injury fall since his admission. R40's "Care Plan" documented the following interventions: 03/05/2026 – Staff would follow facility fall protocol. Staff would ensure his call light was within reach and encourage him to use it for assistance as needed. Staff would answer the call light promptly to all requests for assistance. Staff would educate R40, his family, and caregivers about safety reminders and what to do if a fall occurred. 03/13/2026 – Staff would continue interventions on the at-risk plan. Staff would provide activities that promote exercise and strength building where possible. Staff provide one-on-one activity if bedbound. Therapy would consult for strength and mobility. 03/16/2026 - Staff would encourage him to participate in activities that promoted exercise, physical activity for strengthening, and improved mobility. Staff would ensure that he was wearing appropriate footwear when ambulating or mobilizing in a wheelchair. Staff would provide a safe environment with even floors, free from spills, clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night, and personal items within reach.			F0689			

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F0689 SS = D	Continued from page 35 03/25/26 – Staff would assist him back to bed after meals. 04/05/2026 – Staff would ensure bed was in the lowest position. 05/27/2026 - Medication review would be completed. Staff was educated on proper positioning of the wheelchair and use of a gait belt during transfers. 06/12/2026 – Staff would assist R40 back to bed after meals and ensure the footrests on his wheelchair are in the open position. Medication adjustments for pain 06/22/2026 – Staff would ensure there were fall mats beside bed 06/23/2026 - Behavior of placing self on the floor has been added to care plan. 06/30/2026 – Call light highlighted. Staff placed a sign in his room to remind him to call for assistance with transfers 08/03/26 - Psych services would complete a medication regimen review. 08/10/2026 - Pain medication regimen adjusted. On 08/10/2026 at 08:40 AM, R40 laid on his bed. The bed was in the lowest position, the fall mat was leaned against the wall, his wheelchair was out of his reach, his call light was on the floor between the bed and wall, and the call light box was pulled from the wall and laid on the side of the bed. On 08/10/2026 at 09:45 AM, Certified Nurse Aide (CNA) P stated R36 and R40 were very high risk for falls. CNA P stated it was everyone's responsibility to ensure fall interventions are in place. CNA P stated the fall interventions could be found on the Kardex (nursing tool that gives a brief overview of the care needs of each resident), which contained the care planned fall interventions. On 08/12/2026 at 10:01 AM, Licensed Nurse (LN) I stated everyone had access to the Kardex and care plans. LN I stated R36 and R40 were high fall risks. LN I stated it was everyone's responsibility to ensure fall interventions were in place. LN I stated after a fall, the staff that worked in that area would do a huddle meeting to discuss the fall and come up	F0689					

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F0689 SS = D	Continued from page 36 with a new intervention. LN I stated that the intervention would not be started until the director of nursing could review the fall intervention and change if needed. On 08/12/2026 at 11:50 AM, Administrative Nurse D stated the staff would gather and discuss a resident's fall to come up with a new fall intervention. Administrative Nurse D stated she would expect all fall interventions to be on the care plan. Administrative Nurse D stated new interventions would be communicated by word of mouth, care plan, Kardex, tasks, and on the resident's orders. The facility's "Fall Prevention program" policy dated 10/06/2025 documented each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.	F0689					
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: 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) 9. Findings included: - R9s Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), dependence on renal dialysis (a procedure where impurities or wastes are removed from the blood), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The "Quarterly Minimum Data Set (MDS)" dated 07/16/2026 documented a Brief Interview of Mental	F0698					

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F0698 SS = D	Continued from page 37 Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R9 had received dialysis treatment during the observation period. R9's "Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA)", dated 09/26/2025, documented she had occasional incontinence and requires some assistance with toileting hygiene. R9's "Care Plan" documented the following interventions: 09/18/2024 – staff would communicate with the dialysis center regarding medications, diet, and lab results. Staff would coordinate care in collaboration with the dialysis center. Staff would monitor vital signs pre- and post-dialysis. Staff would notify the physician of any significant abnormalities. R9's EMR under the "Misc" tab revealed the following "Dialysis Communication Form" reviewed from 05/01/2026 to 08/10/2026 revealed the following eleven days post dialysis assessment was completed: 05/04/2026, 05/06/2026, 05/11/2026, 06/10/2026, 06/12/2026, 06/15/2026, 06/24/2026, 06/26/2026, 07/20/2026, 08/07/2026, and 08/10/2026. On 08/10/2026 at 08:30 AM, R9 laid on her bed in the lowest position. She indicated she was unable to communicate in English. Facility staff stated R9 had a translation app on her phone. R9 refused to allow surveyor to use her phone for communication. Staff stated there was a staff member that assisted R9 with communication with other staff to make her needs known. On 08/10/2026 at 09:45 AM, Certified Nurse Aide (CNA) P stated she would assist R9 with getting ready for dialysis appointment. CNA P stated she would ensure R9 had her communication book with her when she left for dialysis. On 08/12/2026 at 10:01 AM, Licensed nurse (LN) I stated she would obtain R9's vital signs and weight pre and post dialysis treatments. LN I stated if R9 returned before the end of dayshift she would complete the post-dialysis assessment and document the assessment on the communication	F0698					

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F0698 SS = D	Continued from page 38 sheet. On 08/12/2026 at 11:50 AM, Administrative Nurse D stated she expected the charge nurse to complete the post dialysis assessment for R9 upon her return for dialysis. Administrative Nurse D stated the dialysis communication sheet would then be placed in a folder for medical records to scan into R9's EMR. 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			
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure a functional call light system for Resident (R)28 to convey his needs to staff. Findings included: R28's Electronic Medical Record (EMR) showed a diagnosis of muscle weakness, repeated falls, encephalopathy (a broad term for any brain disease that alters brain function or structure), syncope (fainting or passing out) and collapse, weakness and cognitive impairment (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and a need for assistance with personal care.			F0919			

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F0919 SS = D	Continued from page 39 The "Admission Minimum Data Set (MDS)," dated 7/23/2026, documented a Brief Interview for Mental Status (BIMS) of 14, which indicated he was cognitively intact. R28's "Care Plan" dated 07/20/2026 stated R28 was at risk for falls due to multiple falls at home prior to arrival, encephalopathy, syncope and collapse, weakness, and cognitive impairment. Make sure his call light was within his reach and encourage him to use it for assistance as needed. Observed on 08/11/2026 at 03:21 PM, R28 pushed his call light and had no notification to alert staff on the call system monitor. Observed on 08/12/2026 at 07:36 AM, R28 had pushed his call light, and there was no alert to staff on the call system monitor. During an interview on 08/11/2026 at 03:21 PM, R28 stated that his call light did not work and he had called for help and no one came. During an interview on 08/12/2026 at 07:48 AM, Licensed Nurse (LN) G stated that the call light should always be in R28's reach and working. If a call light was not in working order, then a bell would be given to him, and a work order for it to be fixed would be placed in the computer tracking system called TELS that would alert maintenance on the computer that the call light was not working. During an interview on 08/12/2026 at 07:51 AM, Certified Nurse Aide (CNA) Q stated that if a call light was found not working, then she would go find maintenance by looking for them or place a work order in the TELS system for maintenance. She would also notify the nurse. During an interview on 08/12/2026 at 08:42 AM, Maintenance U stated that when they get a work order, it will tell them if it is critical or not. They worked on the critical work orders first and went down the list. Maintenance U said there were two maintenance staff members, and they will both work together and go through all the work orders alerted to them on the TELS and finish them all before leaving for the day. He stated that maintenance			F0919			

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F0919 SS = D	Continued from page 40 checked the call lights daily by going to each unit and checking one room to see if it is working and documenting it on the computer. He stated that the call lights take batteries to operate so the nursing staff was supposed to be checking the residents on their units daily. Maintenance U said the staff was to send a work order notifying them if the call light was not working. He stated that he did not have a work order for R28's room for a call light not working, so he was not aware it was not working. Maintenance U then went and checked the call light in R28's room and verified the battery was dead. During an interview on 08/12/2026 at 11:45 AM, Administrative Nurse D stated that the call light should always be working and in R28's reach. The nursing staff should be checking the call lights when a new resident comes in, but it was up to maintenance to check all the lights once a month. She stated that the call light should notify the staff by the call system and stay on if the battery were to go dead. R28's room had not alerted the staff that the battery was dead. The policy "Call Lights: Accessibility and Timely Response" dated 12/01/2025 documented that the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Ensure the call system alerts staff members directly or goes to a centralized staff work area.			F0919			
F0851 SS = C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through			F0851			

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F0851 SS = C	Continued from page 41 interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to submit complete and accurate staffing			F0851			

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F0851 SS = C	Continued from page 42 information to the federal regulatory agency through Payroll Based Journaling (PBJ). Findings included: - The "PBJ Staffing Data Report CASPER Report 1705D" provided by the Centers for Medicaid and Medicare (CMS) for Fiscal Year (FY) 2026 Quarter (Q), Q2, and Q4 documented excessively low weekend staffing. Review of the facility's actual working schedule sheets from 02/11/2025 to 08/11/2026 revealed the facility maintained and had the same number of staff scheduled and worked as during the week: Two nurses for day shift, and two nurses for evening and night shift; six to eight nurse aides on day shift, and five to seven nurse aides on evening and four to five nurses' aides on night shift; and two medication aide on day and evening shift. The facility's "Facility Assessment" revised on 01/15/2026 documented the specific needs of each resident in the community were identified, and staffing was adjusted as needed. The facility assessment included staffing for each shift. The direct care staff was to have two licensed nurses for day shift, and two licensed nurses for evening and night; two to three medication aids on day and evenings; six to eight nurse aids on day shift and six to seven nurse aides on evening shift, and four to five nurse aids' night shift. On 04/21/26 at 08:06 AM, Administrative Staff A stated he was unsure why the PBJ triggered for excessively low weekend staff. He stated the facility had been fully staffed for the last six months with its own employees. Administrative Staff A stated the PBJ was generated by the corporate office. He stated the corporate office sends the report to him to review and look for any discrepancies before submitting. The facility's "Payroll Based Journal" dated 02/05/2025 documented it was the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.			F0851			