

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/19/2026	
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY , OVERLAND PARK, Kansas, 66207			
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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 3092710 and 3105702. The census was 38. The sample included 13 residents.			F0000			
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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			F0880			

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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F0880 SS = F	Continued from page 1 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) were used for two residents, Resident 38, who had a draining wound and R51, who had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder).	F0880					

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F0880 SS = F	Continued from page 2 Findings included - On 08/17/2026 at 02:55 PM, R38 sat in her wheelchair with slippers on, and her legs were not elevated. R38's legs were wrapped with an Ace wrap, and there was visible brownish drainage that had seeped through the wrap. Licensed Nurse (LN) G came into the room, washed her hands, and donned clean gloves. LN G placed a chuck (a disposable, highly absorbent under pad used to protect surfaces from bodily fluids) on the floor under R39's feet and a chuck on the bed and set all the dressing for the wound care on it. LN G set a package of 4 x 4 gauze squares on the chucks on the floor and stated, "Your slippers are wet from the drainage from your legs." LN G removed the ACE wrap and the dressings from her leg. LN G placed the soiled dressing in a black trash bag and removed her soiled gloves. LN G donned a clean pair of gloves, grabbed a 4x4 gauze square, sprayed the opened area, which was approximately 5 centimeters (cm) x 5 cm, and leg with wound cleansed, and cleansed the areas. LN G then grabbed another 4x4 out of the package with the same soiled gloves. LN G did this three more times. LN G removed her soiled gloves, donned a clean pair, and another nurse, LN I, came into the room to assist her. LN H donned a pair of clean gloves and helped hold up R38's right leg. LN G packed the wound with Maxorb 2 (ultra-absorbent made from 100% calcium alginate) and changed her gloves. LN G placed Xeroform on her inner and back calf and then applied Sorbex pads to the back and front of her leg, wrapped her leg with Kerlix, and then the Ace wrap from her toes to her knee. LN G then unwrapped the Ace wrap from her left leg and removed all the dressings. There was a lot of drainage from the dressings, and she stated she would call to get an order to change the dressings twice a day. LN G removed her soiled gloves, donned clean gloves, and used wound cleanser to cleanse her left leg. LN G removed her soiled gloves, donned a clean pair, and put lotion on her left calf, wrapped her calf with Kerlix, and then applied the Ace wrap from her toes to her knees. LN H stated, "We are going to try to find some elevated foot pedals so you can elevate your legs." R38 stated that she would not keep them elevated for very long. LN I removed his gloves, donned a new pair of gloves, and took the bag of soiled dressings out of the room. LN G then removed her gloves, washed her hands, and told R38 she would get her a pair of socks to put on her feet because her slippers were wet and needed to be washed.			F0880			

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F0880 SS = F	Continued from page 3 On 08/17/2026 at 03:30 PM, LN G stated they do not measure the wound because she was seen by wound care. LN G further stated that she was not aware there should be EBP for R38. LN G stated she would contact the physician to get an order for the EBP. On 08/17/2026 at 04:00 PM, Administrative Nurse D stated that, since the wound was open and draining, there should have been EBP for R38 and would provide education to the staff. On 08/18/2026 at 02:40 PM, R51 sat in his wheelchair in his room. At the entrance of his room was EBP signage and a three-drawer plastic storage container with disposable gowns. Certified Nurse Aide M grabbed a mask and stated, R51's wife would like all visitors to wear a mask when in contact with R51. CNA M put the mask on but did not get a gown out of the storage container. CNA M washed her hands, donned clean gloves, alcohol pads, a black plastic bag, and a graduated specimen container (a specialized medical device used to measure liquid output). She went behind R51's wheelchair, set the plastic trash bag on the floor, put the specimen container in the bag, and sat down in his recliner. CNA M removed the drain from the drain holder and wiped the drain with an alcohol wipe, unclamped it, and drained the urine from the catheter bag into the container. CNA M reclapsed the drain, wiped the drain opening with an alcohol wipe, and inserted it back into the drain holder. CNA M took the specimen container into the bathroom, disposed of the urine, removed her gloves, and washed her hands. As we left R51's room, I asked her what the three-drawer plastic storage container was for, and she stated she thought it was for R51's neighbor. I then pointed to the EBP signage and asked her if she should have worn a gown while draining his catheter. CNA M stated, "Oh, that must be new, but I should have worn a gown." On 08/19/2026 at 08:30 PM, Licensed Nurse H stated he has had EBP since admission and staff are to wear a gown, gloves, and mask while providing care. On 08/19/2026 at 03:00 PM, Administrative Nurse D stated she would provide staff education regarding EBP and infection control. The facility's "Enhanced Barrier Precautions," undated policy, documented the facility would adhere to guidance provided by the Centers for Disease Control (CDC) regarding prevention of spread of multidrug-resistant organisms with the			F0880			

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F0880 SS = F	Continued from page 4 use of EBP. Residents would be placed on EBP when Contact Precautions do not otherwise apply, with chronic wounds, an indwelling medical device, and infection or colonization with a CDC-targeted MDRO (multidrug-resistant organism). Staff would don gowns and gloves during high-contact resident care activities, and signage would be posted outside the resident's room indicating the type of precautions, required personal protective equipment (PPE-gowns, face shields and/or eye protection, and gloves), and high-contact resident care activities. The required PPE would be available inside the resident's room.	F0880					
F0628 SS = E	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-	F0628					

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F0628 SS = E	Continued from page 5 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred	F0628					

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F0628 SS = E	Continued from page 6 or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as 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-	F0628					

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F0628 SS = E	Continued from page 7 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to provide Resident (R) 6, R1, R2, and R48 and their representative with a bed hold	F0628					

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F0628 SS = E	Continued from page 8 and notification of transfer when sent to the hospital. The facility failed to ensure the long-term care ombudsman was notified of R1's transfers to the hospital. The facility failed to complete and provide R1, R2, and R48 and their representatives a discharge summary and recapitulation of stay when discharged from the facility. Findings included: - 1. R1 Electronic Medical Record (EMR) documented a "Discharge Minimum Data Set (MDS)," dated 03/17/2026, documenting a planned discharge to the community with a return not anticipated. - R1's "Entry MDS," dated 4/17/2026, documented a re-entry to the facility from an acute hospital. - R1's "Discharge MDS," dated 04/28/2026, documented an unplanned discharge to an acute hospital with a return anticipated. - R1's "Entry MDS," dated 06/19/2026, documented a re-entry to the facility from an acute hospital. - R1's "Discharge MDS," dated 04/28/2026, documented an unplanned discharge to an acute hospital with a return anticipated. - R1's "Entry MDS," dated 05/07/2026, documented a re-entry to the facility from an acute hospital. - R1's "Discharge MDS," dated 05/18/2026, documented an unplanned discharge to an acute hospital with a return anticipated. - R1's "Entry MDS," dated 05/24/2026, documented a re-entry to the facility from an acute hospital. - R1's "Discharge MDS," dated 06/02/2026, documented a planned discharge home with a return not anticipated. - R1's "Entry MDS," dated 06/12/2026, documented a re-entry to the facility from an acute hospital. On 08/19/2026 at 08:4 AM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R1. The facility lacked evidence and was unable to provide the requested bed hold and notice of transfer information regarding R1's transfers to the hospital on 04/28/2026 and 05/18/2026. The facility failed to notify the LTCO when R1 was transferred to the hospital on 05/18/2026 and her discharge home on 06/02/2026.			F0628			

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F0628 SS = E	Continued from page 9 A Discharge Summary and recapitulation of stay were not provided to R1 or her representative upon her discharge home on 03/17/2026 and 06/02/2026. 2. R2's EMR documented a "Discharge MDS," dated 06/08/2026, documenting an unplanned discharge to an acute hospital with a return anticipated. R2's "Entry MDS," dated 06/12/2026, documented a re-entry to the facility from an acute hospital. R2's "Discharge MDS," dated 06/30/2026, documented an unplanned discharge to an acute hospital with a return not anticipated. R2's "Entry MDS," dated 07/13/2026, documented a re-entry to the facility from an acute hospital. R2's "Discharge MDS," dated 08/04/2026, documented a planned discharge to home/community with a return not anticipated. R2's "Entry MDS," dated 08/13/2026, documented a re-entry to the facility from an acute hospital. On 08/19/2026 at 08:4 AM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R2. The facility was unable to provide the requested bed hold and notice of transfer information regarding R2's transfers to the hospital on 06/08/2026 and 06/30/2026. A Discharge Summary and recapitulation of stay were not provided to R2 or her representative upon her discharges home on 06/30/2026 and 08/04/2026. 3. R48's EMR documented an unplanned discharge to an acute hospital with a return anticipated. R48 did not return to the facility after her transfer to the hospital. On 08/19/2026 at 08:4 AM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R48. The facility was unable to provide the requested bed hold and notice of transfer information regarding R48's transfer to the hospital on 02/12/2026. A Discharge Summary and recapitulation of stay was not provided to R48 or her representative upon her discharge from the facility after she did not return to the facility after her hospital stay. On 08/19/2026 at 11:14 AM, Administrative Staff A stated that he was unable to find the bed hold and notice of transfer for R1, R2, and R48. Administrative	F0628					

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F0628 SS = E	Continued from page 10 Staff A stated that nursing had been responsible for completing the bed holds and notice of transfers but that task responsibility had been dropped and was not being completed as they should. Administrative Staff A stated that upon a residents discharge, the discharge summary and recapitulation of stay should have been completed for these residents. Administrative Staff A stated a project improvement plan has been implemented to address and resolve these problems. Administrative Staff A stated that the notices to the ombudsman were mailed monthly but could not state why some of the transfers or discharges had been omitted. The facility's "Bed Hold" policy dated 01/06/2026 documented: At the time of transfer, or within 24 hours if the transfer is emergent, a facility representative will provide the bed-hold policy acknowledgement form to the patient or patients representative. The facility will hold the patient's bed until admission as an inpatient or after midnight. Payment received during the Bed Hold period is for the purpose of reserving a bed and maintaining the patient's personal effects during the patient's absence and does not represent a payment for the act of readmission at a later date. Patients electing a Bed Hold are guaranteed a bed within the facility. Bed holds will be renewed daily or until revocation. The patient or patients representative may cancel the bed hold at any time. Refunds will not be issued for any days that have already been used. Patients electing not to initiate a Bed Hold will be granted readmission to the next available bed. The facility's "Patient Transfer" policy dated 12/22/2023 documented: The facility will not transfer or discharge the resident while an appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility will document in the progress notes the danger that failure to transfer or discharge would pose. Residents who are sent emergently to an acute care setting are considered transfers, not discharges. Prior to initiating a transfer or discharge, the facility will document reasonable efforts to meet the resident's needs and prevent transfer or discharge, unless immediate transfer is required for safety or medical necessity. The transfer will be documented in the residents progress notes. The following information will be communicated to the receiving provider via the CCD and/or discharge summary: Contact information of the practitioner responsible for the care of the resident; resident representative information; advance directive information; special			F0628			

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NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY , OVERLAND PARK, Kansas, 66207			
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F0628 SS = E	Continued from page 11 instructions or precautions for ongoing care; comprehensive care plan goals; the CCD and/or discharge summary will be provided to the receiving provider prior to or at the time of transfer; prior to transferring a resident the facility will notify the resident/representative of the transfer via the Transfer or Discharge Notice form. The notice will include: the specific reason for the transfer or discharge; the effective date; the specific location; an explanation of the right to appeal; contact information for the Office of the State Long-Term Care Ombudsman; contact information for the Disability Law Center. The notice will be provided at least 30 days prior to the transfer or discharge of the patient unless: the health and/or safety of individuals in the facility would be endangered due to clinical or behavioral status; health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by urgent medical needs; has not resided in the facility for 30 days; a resident who is hospitalized or on a therapeutic leave will be offered a bed hold; the facility will notify the Ombudsman when required. - The "Nurse's Note," dated 07/18/2026 at 01:31 PM, documented R6 was admitted to the hospital for pain in the right arm and diarrhea. R6 requested to be transferred to the hospital for further evaluation. R6's clinical record lacked evidence of a bed hold, or a notice of transfer was provided to the resident representative. On 08/18/2026 at 03:00 PM, Consultant GG stated that they were unable to find evidence that a bed hold or a notice of transfer was provided to the resident or representative. Consultant GG further stated that the facility did not do a recapitulation (a concise summary of the resident's stay and course of treatment in the facility)) after she did not return to the facility from the hospital. The facility's "Bed Hold" undated policy documented that, if a resident required transfer to an acute hospital or went on therapeutic leave, the facility would offer the patient the opportunity to hold a bed while they are discharged from the facility. At the time of transfer, or within 24 hours if the transfer was emergent, a facility representative would provide the bed-hold policy acknowledgement form to the resident or representative.	F0628					

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F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to promote dignity for two sampled residents, Resident R38 and R60, when staff left the gait belts (an assistive transfer device that is secured snugly around a resident's natural waist to provide a healthcare provider a secure handhold	F0550					

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F0550 SS = D	Continued from page 13 during ambulation and physical transfer) applied for extended periods while in the wheelchair without actively transferring them. Findings included: - The Electronic Medical Record (EMR) for R38 documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, hypertensive heart disease (a group of heart problems caused by long-term, unmanaged high blood pressure), and chronic respiratory failure (when your lungs cannot move enough oxygen into your blood or they cannot remove enough carbon dioxide from the blood). The "Admission Minimum Data Set" (MDS), dated 07/28/26, documented R38 had severely impaired cognition. R38 was dependent upon staff for toileting hygiene, transfers, mobility, and did not ambulate. The "Care Plan," dated 07/31/26, directed staff to assist with transfers and ambulation as needed, and ensure proper placement of call light and assistive devices for ease of access. On 08/17/2026 at 11:22 AM, R38 sat in her wheelchair; she had a gait belt on that was tightly secured above her breasts. R38 stated that the gait belt had been on her all morning and did not want it left on, as she had not been recently transferred. On 08/17/2026, at 01:30 PM, R38 sat in her wheelchair; she had a gait belt on that was tightly secured above her breasts. R38 stated she had not been recently transferred. 08/17/2026 at 02:30 PM, Licensed Nurse (LN) G stated the gait belt should not be left on the resident unless the resident was being transferred or ambulating. On 08/18/2026 at 02:40 PM, Certified Nurse Aide (CNA) M stated that the gait belt should be removed from the resident after the resident was transferred. The facility's "Resident Rights" undated policy documented that the resident had a right to a dignified existence. The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F0550					

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F0550 SS = D	Continued from page 14 individuality. The facility must promote the rights of the residents. On 08/17/2026 at 10:54 AM, R60 laid in his bed. A gait belt was still secured on him just below his armpits. R60 complained of discomfort due to the gait belt and could not state how long it had been left on.	F0550					
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Resident (R)38 had a physician's order and was assessed for the ability to safely self-administer medications for her inhaler (a small, handheld medical device that delivers medication directly into the lungs when you breathe in), which was left at the bedside. Findings included: - The Electronic Medical Record (EMR) for R38 documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, hypertensive heart disease (a group of heart problems caused by long-term, unmanaged high blood pressure), and chronic respiratory failure (when your lungs cannot move enough oxygen into your blood or they cannot remove enough carbon dioxide from the blood). The "Admission Minimum Data Set" (MDS), dated 07/28/26, documented R38 had severely impaired cognition. R38 was dependent upon staff for toileting hygiene, transfers, mobility, and did not ambulate. The MDS documented R38 shortness of air with exertion, at rest, and when lying flat. The "Care Plan," dated 07/31/2026, directed staff to assess lung sounds and monitor vital signs, oxygen saturation (percentage of oxygen in the blood) at least daily and as needed for signs and symptoms of respiratory distress. The care plan directed staff to	F0554					

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F0554 SS = D	Continued from page 15 administer medication and obtain labs as ordered by the physician, oxygen as ordered, and schedule cares and activities to allow for adequate rest. The care plan failed to reflect the specific medication or bedside placement of the inhaler medication. The "Physician's Order," dated 07/31/2026, directed staff to use an albuterol sulfate HFA aerosol inhaler, 90 micrograms (mcg/actuation), two puffs, every six hours, as needed for shortness of breath. The order did not state it could be left at the bedside. On 08/17/2026 at 11:22 AM, R38 sat in her wheelchair. On the bedside table next to her lay an inhaler. R38 stated it was her rescue inhaler, and she used it when needed. On 08/17/2026 at 04:30 PM, Licensed Nurse (LN) G stated there was no order for R38 to have the inhaler at bedside but felt she could self-administer the inhaler and did not know if there was an assessment for self-administration of the inhaler. On 08/17/2026 at 04:23 PM, Administrative Nurse D verified the facility had not assessed R38 to have the inhaler at bedside or an order. Administrative Nurse D further stated that the inhaler and whether she was able to self-administer the medication should be on the care plan. The facility's "Self-Medication Administration" undated policy documented that residents may self-administer medications if it was determined that they can do so safely and consistently. As part of their overall evaluation, staff would assess each resident's mental and physical abilities to determine whether a resident could self-administer medications. In addition to general evaluation of decision-making capacity, staff would perform a more specific skill assessment utilizing the "Self-Administration Assessment" form.	F0554			
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience,	F0605			

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F0605 SS = D	Continued from page 16 and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F0605					

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F0605 SS = D	Continued from page 17 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by:	F0605					

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F0605 SS = D	Continued from page 18 Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 1 and R17 was free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications without a Centers for Medicare and Medicaid (CMS) appropriate indication for use. Findings included: - 1. R1's Electronic Medical Record (EMR) documented diagnoses of metabolic encephalopathy (a broad term for brain dysfunction caused by an underlying systemic illness in the blood) and disorientation (a state of mental confusion where a person loses their sense of direction, position, or awareness). R1's "Annual Minimum Data Set (MDS)" dated 06/18/2026 documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R1 required substantial/maximum assist to being dependent on staff for her cares. R1 received an antipsychotic and an antidepressant (a class of medications used to treat mood disorders). R1's "Psychotropic Care Area Assessment (CAA)" dated 06/25/2026 documented she received psychotropic medications and was at risk for side effects. The care plan would be developed to monitor adverse effects and evaluate the medication response. R1's Care Plan directed staff she was taking medications with a Black Box Warning (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration). She was on the antipsychotic medication Seroquel for management of mood disorders. Staff were directed to administer as directed and monitor for adverse effects. R1's "Orders" tab of the EMR documented an order dated 06/12/2026 for Seroquel 25 milligrams (mg) tablet at bedtime for delirium (sudden severe confusion, disorientation, and restlessness). This order lacked an appropriate indication for use of an antipsychotic medication. R1's EMR lacked documentation of a physician's rationale for the inappropriate indication along with a risk versus benefits review and evidence of non-pharmacological interventions that were attempted but unsuccessful.			F0605			

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F0605 SS = D	Continued from page 19 On 08/18/2026 at 11:30 AM, R1 was getting prepared to go to the dialysis (a procedure where impurities or wastes are removed from the blood) center for her scheduled treatments. - 2. R17's EMR documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion and aggressive behaviors) and altered mental status a sudden or gradual change in a person's normal thinking, awareness, attention, or level of consciousness. R17's Admission MDS dated 08/06/2026 documented he had both long- and short-term memory problems. R17 displayed no behavioral symptoms or any indicators of psychosis (any major mental disorder characterized by a gross impairment in reality perception). R17 was taking antipsychotic and an antidepressant medication. R17's "Psychotropic Medication Use CAA" dated 08/14/2026 documented this CAA triggered related to him psychotropic medication. See medication administration record and progress notes. Care Plan will address use of the psychotropic drug use. R17's Care Plan dated 07/31/2026 directed staff that he received the antipsychotic medications of aripiprazole, Rexulti, and Seroquel for management and treatment of psychosis associated with Alzheimer's with paranoia and hallucinations. R17's "Orders" tab of the EMR documented a physician's order dated 07/31/2026 for Seroquel 25 mg tablet by mouth at bedtime for hallucinations and paranoia. This antipsychotic medication does not have an approved indication for use. R1's EMR lacked documentation of a physician's rationale for the inappropriate indication along with a risk versus benefits review and evidence of non-pharmacological interventions that were attempted but unsuccessful. On 08/18/2026 at 07:50 AM, R17 was still resting in bed. Bed in low position, call light is within reach. On 08/18/2026 at 07:51 AM, Licensed Nurse (LN) J stated that antipsychotic medications should not be used if they don't have the appropriate indication			F0605			

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F0605 SS = D	Continued from page 20 for use. LN J stated that some of the residents come from the hospital on them. On 08/19/2026 at 02:13 PM, Consultant GG stated that residents coming here for rehab and short stays were often prescribed an antipsychotic in the hospital and continued the medication when they came here. Consultant GG stated that management had been working on getting away from the residents being on the antipsychotic without the appropriate indication for their use. The facility's policy for Psychotropic/Antipsychotic Medication use was requested on 08/20/2026 but was not received.			F0605			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide consistent bathing and grooming as care planned for Resident (R)38, and the facility failed to ensure dependent resident R60 was provided toileting as needed, which resulted in him having a bowel movement and a fall while attempting to get to the bathroom. Findings included: - R60's Electronic Medical Record (EMR) documented diagnoses of respiratory failure (when your lungs cannot move enough oxygen into your blood, or they cannot remove enough carbon dioxide from your blood), aspiration pneumonia (a lung infection that happens when you breathe food, liquid, vomit, or spit into your airways), vascular dementia (a decline in thinking skills caused by blocked or reduced blood flow to the brain), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).			F0677			

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F0677 SS = D	Continued from page 21 R60's "Admission Minimum Data Set (MDS)" was not completed as he admitted the facility on 08/13/2026. R60's "Care Area Assessments (CAA)" had not yet been completed. R60's Care Plan dated 08/14/2026 directed staff to be sure his call light was in reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance; to keep bed in the lowest position; place mattress on the floor next to the bed to reduce the risk of injury in the event of a fall; provide verbal reminders/cues to ask for assistance as needed. An intervention dated 08/15/2026 directed staff to add bolsters to the bed. An intervention dated 08/17/2026 directed staff to conduct scheduled safety checks at least every two hours and as needed. During rounds, assess him for toileting needs, pain/discomfort, positioning, hunger/thirst, and need for assistance; offer toileting, fluids, snacks, and other comfort measures as appropriate; ensure call light and personal items are within reach and maintain a safe, clutter-free environment. R60's "Admission Nursing Observation with pain interview" dated 08/13/2026 indicated he had incontinence of bowel and bladder and required assistance for transfers and toileting. R60 was a fall risk score of 15, which indicated he was a moderate risk for falls due to noncompliance. Goal: Patient will remain free from serious injury related to falls with appropriate interventions in place while maintaining patient's independence and rights, including the right to refuse interventions with appropriate informed decision making. On 08/14/2026, R60's daughter was present in his room, and she requested he be bathed. On 08/16/2026 around 12:20 PM, R60's daughter arrived at his room. R60 was lying on the floor of his room, the blue floor mat was covered in feces, and he said he was trying to get to the bathroom. R60's daughter asked for assistance from an aide for help and the aide stated R60 was not her resident and she left the room to get R60's aide. R60's mat and bedding were changed and then he was transferred back to his bed, where his daughter noticed he still had dried feces on his arm. R60's daughter asked staff if he could get a shower and the staff member told her that if the facility had more resources, he might receive a shower but			F0677			

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F0677 SS = D	Continued from page 22 would most likely receive a bed bath. R60's daughter had requested every day since 08/14/2026 for her father to be bathed and had still not received one as of 08/17/2026. On 08/17/2026 10:54 AM, resident laid in his bed with his gait belt secured around him. R60's daughter was present in the room. R60 wore a hospital gown and his hair was a mess and gown soiled. On 08/18/2026 at 10:45 AM, R60 laid in his bed, had his supplemental oxygen on, his bed was in low position. R60 had a hospital gown on and his hair was disheveled. On 08/19/2026 at 02:13 PM, Consultant GG stated that bathing/showers days should be established upon admission. Consultant GG stated that staff would try to accommodate a resident or their family's request for bathing to be completed. Consultant GG stated that staff should have done a better job cleaning R60 up after an incontinent episode, and she would speak with staff regarding R60's cares and family concerns regarding his care. - The Electronic Medical Record (EMR) for R38 documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, hypertensive heart disease (a group of heart problems caused by long-term, unmanaged high blood pressure), and chronic respiratory failure (when your lungs cannot move enough oxygen into your blood or they cannot remove enough carbon dioxide from the blood). The "Admission Minimum Data Set" (MDS), dated 07/28/26, documented R38 had severely impaired cognition. R38 was dependent upon staff for toileting hygiene, transfers, mobility, and supervision with bathing. The "Care Plan," dated 07/31/2026, directed staff to assist with showers twice weekly and as needed per her preference; the staff set up items at the sink for daily hygiene, and staff will assist as needed for all activities of daily living. The "Physician's Order," dated 07/22/2026, directed staff to provide showers on Thursday and Sunday, 02:00 PM – 10:00 PM. The order had special instructions for the nurse to offer an alternate day/shift for any refusals and document in a			F0677			

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F0677 SS = D	Continued from page 23 progress note. The "July and August 2026 Shower Sheets and Bathing Record" documented R38 requested showers on Thursday and Sunday evening shift and documented R38 had not received a bath or shower during the following days: 07/29/2026 – 08/08/2026 (11 days) The "August 2026 Shower and Bathing Record" documented R38 reused a shower or bed bath on 08/04/2026. On 08/17/2026 at 02:50 PM, R38 had on a blue shirt that hung off of the left shoulder; her hair was slicked back, greasy, and had dry flaking skin in her hair. R38 stated she now received bed baths because of her legs being wrapped. R38 stated she was supposed to get the bed bath twice a week and it was not getting done. She stated he hair had been washed once but only because she asked, and it was not easy getting her hair washed in a bed pan. On 08/18/2026 at 07:45 AM, R28 sat in her wheelchair; she had on the same blue shirt from the day before. On 08/18/2026 at 02:40 PM, Certified Nurse Aide (CNA) M stated R38 received baths in the evening but was unsure if she ever refused her bathing. CNA M further stated that unless she refused, her clothes are changed daily. On 08/19/2026 at 08:15 AM, R38 sat up in her bed; she had on the same shirt as she had on the previous two days. On 08/19/2026 at 08:30 AM, Licensed Nurse (LN) H stated she did not think R38 ever refused bathing and received them on Thursday and Sunday evening. LN H further stated that she should have her clothes changed every day. On 08/19/2026 at 03:00 PM, Administrative Nurse D stated R38 should receive her bed bath twice a week and, if refused, offered an alternative day, and her clothes should be changed daily. The facility's "Activities of Daily Living (ADL) for Dependent Residents," undated policy documented the facility would provide care and services to ensure that each resident attains and maintains the highest practicable level of physical functioning, unless a decline is avoidable. Services are provided in accordance with the resident's comprehensive			F0677			

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F0677 SS = D	Continued from page 24 assessment, interdisciplinary care plan, goals, preferences, and clinical condition.	F0677					
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R)56's non-pressure wounds were appropriately assessed and documented upon his admission. The facility failed to ensure that R38's wounds were care planned with staff direction on wound care. Findings included: - The Electronic Medical Record (EMR) for R38 documented diagnoses of lymphedema (swelling caused by accumulation of lymph), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, hypertensive heart disease (a group of heart problems caused by long-term, unmanaged high blood pressure), and chronic respiratory failure (when your lungs cannot move enough oxygen into your blood or they cannot remove enough carbon dioxide from the blood). The "Admission Minimum Data Set" (MDS), dated 07/28/26, documented R38 had severely impaired cognition. R38 was dependent upon staff for toileting hygiene, transfers, mobility, and did not ambulate. The MDS documented R38 had no skin issues. R38's "Care Plan," dated 07/31/2026, directed staff to consider a specialty mattress or bed, elevate her heels and use protectors, encourage and/or assist to reposition at least every two hours, and keep skin clean and dry. The care plan further directed staff to monitor skin daily during care and report any changes to the Licensed Nurse and/or physician, use a pressure-reducing cushion in her wheelchair,	F0684					

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F0684 SS = D	Continued from page 25 and perform weekly skin assessments. The care plan lacked direction to staff for interventions related to her lymphedema and hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) wound care. The "Physician's Note," dated 07/29/2026 at 6:20 PM, documented R38 had a large hematoma with moderate drainage and no obvious signs of infection. There was some mixed granulation (new tissue formed during wound healing), dermis (the thick layer of living tissue below the outer layer of skin), blistering (a bubble or raised pocket of fluid that forms under the top layers of the skin), and some dark nonviable tissue (something that cannot live or grow). The note further directed staff to use Xeroform (sterile on-adhering fine mesh gauze treated with a bacteriostatic agent), ABD pads (lard pad to absorb drainage), and kerlix/ACE (stretchy gauze bandage) wrapped from toes to knees, change them three times per week and as needed, and offload (removing or reducing weight and pressure from a specific part of the body) areas as much as possible). The "Physician's Note," dated 08/04/2026 at 02:3 PM, documented R38's left calf swelling had improved but still had a lot of old hematoma blood coming from the open areas, and did not have any signs of obvious infection. The note directed staff to continue with the dressing changes as ordered. The "Physician's Note," dated 08/04/2026 at 10:25 PM, documented R38 was seen by a wound care team for the two hematomas to her posterior (back) right calf, and provided education to the resident that she may need to have a surgical intervention due to the risk of infection. The noted documented R38 refused surgical intervention. The "Physician's Note," dated 08/11/26 at 03:58 PM, documented that her right calf swelling had improved, but there was still a lot of old hematoma blood coming from the two open areas, with no obvious sign of infection. The note directed staff to continue with the Xeroform over the open areas of the right calf wound and add silver alginate (an advanced sterile medical wound dressing used to absorb heavy fluid from deep or seeping wounds while releasing silver to kill bacteria and prevent or treat infections) over the Xeroform, the ABD pads wrapped with Kerlix and Ace wrap from her toe to her knees daily. The "Physician's Note," dated 08/14/2026 at 10:09 AM, documented the hematoma site was	F0684					

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F0684 SS = D	Continued from page 26 compromised at some time during the week and was debrided (removing dead, damaged, infected, or contaminated tissues from a wound) during her vascular follow-up. She had dried blood on the Ace wrap on her right lower extremity, and the charge nurse would change the dressing after therapy. The note documented R38 had weeping edema to both legs and increased serosanguineous (semi-thick blood-tinged drainage), odorless drainage. On 08/17/2026 at 02:55 PM, R38 sat in her wheelchair with slippers on and her legs were not elevated. R38's legs were wrapped with an Ace wrap, and there was visible brownish drainage that had seeped through the wrap. Licensed Nurse (LN) G came into the room, washed her hands, and donned clean gloves. LN G placed a chuck (a disposable, highly absorbent under pad used to protect surfaces from bodily fluids) on the floor under R38's feet and a chuck on the bed and set all the dressing for the wound care on it. LN G set a package of 4 x 4 gauze squares on the chucks on the floor and stated, "Your slippers are wet from the drainage from your legs." LN G removed the ACE wrap and the dressings from her leg. LN G placed the soiled dressing in a black trash bag, removed her soiled gloves. LN G donned a clean pair of gloves, grabbed a 4x4 gauze square, sprayed the opened area, which was approximately 5 centimeters (cm) x 5 cm, and leg with wound cleansed, and cleansed the areas. LN G then grabbed another 4x4 out of the package with the same soiled gloves. LN G did this three more times. LN G removed her soiled gloves, donned a clean pair, and another nurse, LN I came into the room to assist her. LN H donned a pair of clean gloves and helped hold up R38's right leg. LN G packed the wound with Maxorb 2 (ultra-absorbent made from 100% calcium alginate) and changed her gloves. LN G placed Xeroform on her inner and back calf and then applied Sorbex pads to the back and front of her leg, wrapped her leg with Kerlix, and then the Ace wrap from her toes to her knee. LN G then unwrapped the Ace wrap from her left leg and removed all the dressings. There was a lot of drainage from the dressings, and she stated she would call to get an order to change the dressings twice a day. LN G removed her soiled gloves, donned clean gloves, and used wound cleanser to cleanse her left leg. LN G removed her soiled gloves, donned a clean pair, and put lotion on her left calf, wrapped her calf with Kerlix, and then applied the Ace wrap from her toes to her knees. LN H stated, "We are going to try to find some elevated foot pedals so you can elevate your legs." R38 stated that she would not keep them elevated for very long. LN I removed his gloves, donned a new pair of			F0684			

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F0684 SS = D	Continued from page 27 gloves, and took the bag of soiled dressings out of the room. LN G then removed her gloves and washed her hands, and told R38 she would get her a pair of socks to put on her feet because her slippers were wet and needed washed. On 08/17/2026 at 03:30 PM, LN G stated they do not measure the wound because she was seen by wound care. LN G further stated that she was not aware there should be Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care). LN G stated she would contact the physician to get an order for the EBP. On 08/17/2026 at 04:00 PM, Administrative Nurse D stated, since the wound was open and draining, there should have been EBP for R38 and would provide education to the staff. The facility's "Patient Care," undated policy documented patient needs are recognized by nursing staff and nursing services are provided to assure that each patient receives care necessary to meet his/her total needs. - 1. R56's Electronic Medical Record (EMR) document diagnoses of varicose veins of left lower extremity with ulcer of unspecified site, cellulitis (skin infection caused by bacteria) of bilateral lower limbs, non-pressure chronic ulcer (an open skin sore caused by poor blood flow, vein problems, or diabetes, rather than physical pressure) of bilateral lower legs, and Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics). R56 Admitted the facility on 08/05/2026, and his "Admission Minimum Data Set (MDS) and Care Area Assessments (CAA) had not been completed. R56's "Observation Detail List Report" documented a Braden Risk Score of 19, which indicated a low risk of pressure ulcer development. He had current skin issues. R56's Baseline Care Plan directed staff that he required assistance with most activities of daily living (ADLs). He used a walker to assist with mobility. The Care Plan directed staff that he needed a wheelchair cushion. Staff were directed to provide treatments as ordered for his pressure ulcer, skin tear, and bilateral lower extremity (BLE) MRSA wounds. The Care Plan directed staff that he had a	F0684					

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F0684 SS = D	Continued from page 28 pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) to his buttock. R56's "Orders" tab of the EMR documented an order for isolation dated 08/05/2026 he was on contact isolation and wound treatment for MRSA. R56's "Orders" tab of the EMR documented an order dated 08/05/2026 for Braden moderate risk: A pressure reducing mattress, pressure reduction cushion to wheelchair, patient education, assist/prompt to turn every two hours, Barrier Ointment to coccyx and bilateral buttocks every shift. R56's "Orders" tab of the EMR documented an order dated 08/05/2026 to cleanse buttock then pat dry. Apply barrier cream then cover with a border foam dressing every day and as needed. R56's "Orders" tab of the EMR documented an order dated 08/06/2026 to cleanse bilateral lower extremity wound and pat dry. Apply Silvadene to the wound bed. Apply Xeroform to wound bed and cover wounds with ABD pad (large pad to absorb drainage), wrap with Kerlix (stretchy gauze bandage) and secure with ACE wrap (elastic stretch bandage) daily on Monday, Wednesday, and Friday. R56's "Orders" tab documented a physician's order for a wound care referral dated 08/05/2026. R56's EMR lacked documentation that his wounds had been assessed to include any measurements, discharge, odor, or staging of the wounds. On 08/19/2026 at 12:32 PM, R56 laid on his bed getting ready for wound care treatment to be done to his BLE. On 08/19/2026 at 11:52 AM, Consultant GG stated that the facility should be doing wound measurements and a more thorough assessment of the wounds when residents are admitted. The facility and corporate policy was not to do the measurements and that the wound care specialist would complete that and document findings. The facility's undated "Admission Skin Assessment" policy documented: Upon admission, the patient will be examined to identify current skin issues. The physician will be contacted to initiate treatment orders if not addressed on the Physician Admit Orders. The admission skin assessment will be			F0684			

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F0684 SS = D	Continued from page 29 uploaded into Resident Documents. The Admitting Nurse will evaluate the patient utilizing the Braden Risk Assessment Scale (BRAS tool used to assess the risk of pressure ulcer development) this assessment/cp is part of the admission nursing observation, determining a numerical score of risk based upon assessment of the patient's overall health status, which includes sensory perception; moisture; activity; mobility; nutrition; friction and shear. Based upon the numerical score identified on the BRAS, the Admitting Nurse will complete the form and initiate the appropriate interventions as suggested on the form by classification of one of four categories of risk (e.g., Low, Moderate, High, and Actual). Not all suggested interventions are appropriate for all patients; therefore, the assessing nurse should evaluate the patient's specific needs and implement interventions accordingly. The Admitting Nurse is responsible for ensuring the selected interventions are initiated, appropriate equipment is placed, and monitoring is placed on the Treatment Record and Baseline Person Centered Care Plan as indicated. The Admitting Nurse will communicate interventions to direct care staff via the completed Care Plan, Baseline Person Centered Care Plan, Treatment Record, Alert Charting and/or verbal report.	F0684					
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that staff properly assessed, measured, and documented pressure ulcer	F0686					

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F0686 SS = D	Continued from page 30 (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) wounds that Resident (R) 1 and R2 admitted the facility with. Findings included: - 1. R1's "Electronic Medical Record (EMR) documented diagnoses of unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure ulcer of sacral (tailbone area), and Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics). R1's "Admission Minimum Data Set (MDS)" dated 05/14/2026 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R1 had impairment on both sides of her upper and lower extremity, and a lift was required for her transfers. R1 required substantial/maximum assist to being dependent on staff for her activity of daily living (ADL) cares. R1 had two unhealed pressure ulcers/injury and a Braden Scale Risk assessment (tool used to assess for the risk of pressure ulcer/injury) used. R1's pressure ulcer was unstageable and was present on admission. Treatments were in place for a pressure reducing device for her chair and bed, a turning program, and pressure ulcer/injury care; application of non-surgical dressings; surgical wound care; application of ointments/medications. R1's "Pressure Ulcer Care Area Assessment (CAA)" dated 05/17/2026 documented she was a new admit with two open areas to coccyx/sacrum on admit, extensive bruising all over and edema. She is receiving new hemodialysis (HD- a procedure where impurities or wastes are removed from the blood), had fragile skin and incontinence episodes, was more dependent on staff for ADL tasks than previous stay. R1's Care Plan dated 05/16/2026 directed staff she admitted with open pressure areas to sacrum/coccyx, extensive bruising and a non-healing right knee surgical wound and was at risk for further skin breakdown and development of open areas related to impaired mobility and fragile skin. The Care Plan directed staff to assess for other moisture problem areas, such as under breasts; barrier ointment as needed; educated patient/family regarding pressure ulcer risk and interventions; encourage and/or assist to reposition at least every	F0686			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0686 SS = D	Continued from page 31 two hours; keep skin clean and dry; pressure reducing cushion to wheelchair; pressure reducing mattress to bed; weekly skin assessments by licensed nurse; and wound care. R1's R2's "Wound Management" tab of the EMR lacked documentation of any wounds and or assessments. R2's "Admission Nursing Observation" dated 05/07/2026 in the EMR documented an admission from the hospital. A Skin assessment the Braden Risk Score of 15 indicating a Moderate Risk for pressure ulcer development; Resident will have decreased risk of developing pressure ulcers with appropriate interventions in place, while maintaining resident's independence and rights. Including the right to refuse interventions with appropriate informed decision making. Resident's current pressure ulcer(s) will heal without s/s of infection within 30 days unless significant medical factors are present which delay or impair normal healing processes; interventions of air mattress, wheelchair cushion, supplements; and wound consult. R1's "Orders" tab of the EMR documented a physician's order dated 05/07/2026 to cleanse sacrum and right knee wound, pat dry, then apply calcium alginate (highly absorbent dressing), then cover with a foam dressing. Change dressing on Monday, Wednesday, and Fridays and as needed. On 08/19/2026 at 12:45 PM, R1 sat in her wheelchair outside the front entrance visiting with her daughter. - 2. R2's EMR Documented diagnoses of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), pressure ulcer of left buttock unstageable, Type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and end-stage renal disease (ESRD-a terminal disease of the kidneys). R2's "Admission MDS" dated 05/18/2026 documented a Brief Interview for Mental Status score of 15, which indicated intact cognition. R2 required partial assistance to being dependent on staff for her cares. R2 was at risk for developing pressure ulcers. The MDS did not indicate that R2 had any pressure ulcers. R2 had skin treatments in place for a pressure reducing device for her chair and bed; and application of nonsurgical dressings.	F0686			

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F0686 SS = D	Continued from page 32 R2's "Pressure Ulcer CAA" dated documented she was a new admit with left buttock perianal abscess (a painful collection of pus in the soft tissue just under the skin near the anus, usually caused by a blocked anal gland)/wound status post debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue), new colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body) created for wound healing and Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) in place, fragile skin, new HD, and impaired mobility. R2's Care Plan initiated on 05/23/2026 directed staff that she admitted with a left buttock/perianal abscess wound status post debridement and was at risk for further skin breakdown and development of open areas related to impaired mobility, fragile skin with new dialysis and Type 2 DM, needing assistance with activities of daily living (ADL) tasks and The revised on 07/23/2026 directed staff to assess for other moisture problem areas, such as under breasts; barrier ointment as needed; educated patient/family regarding pressure ulcer risk and interventions; encourage and/or assist to reposition at least every two hours; keep skin clean and dry; pressure reducing cushion to wheelchair; pressure reducing mattress to bed; monitor skin daily during care and report changes to nurse and/or physician; nutrition consult; weekly skin assessments by licensed nurse; and wound care. R2's "Orders" tab documented a physician's order dated 05/12/2026 to cleanse left buttock wound, apply wet to dry dressing, cover with ABD pad and tape change twice daily and as needed. pack with Dakins's (a mild antiseptic made from diluted sodium hypochlorite bleach and baking soda) soaked gauze, then cover with border foam dressing. R2's "Orders" tab of the EMR documented and order dated 05/12.2026 Braden moderate risk: air mattress, specialty cushion to wheelchair, patient education, assist/prompt turn every 2 hours, barrier ointment to coccyx and bilateral buttocks; pressure reducing mattress, pressure reducing cushion to wheelchair; patient education, assist/prompt to turn every 2 hours, barrier cream to coccyx and bilateral buttocks every shift. R2's "Wound Management" tab of the EMR lacked documentation of any wounds and or assessments. R2's "Admission Nursing Observation" dated 05/12/2026 in the EMR documented a Braden Risk			F0686			

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F0686 SS = D	Continued from page 33 Score of 17- Moderate Risk; Resident will have decreased risk of developing pressure ulcers with appropriate interventions in place, while maintaining resident's independence and rights. Including the right to refuse interventions with appropriate informed decision making. Resident's current pressure ulcer(s) will heal without s/s of infection within 30 days unless significant medical factors are present which delay or impair normal healing processes; interventions of air mattress, wheelchair cushion, supplements; and wound consult. R2's "Admission Nursing Observation" dated 05/12/2026 lacked documentation of R2's wound details, characteristics, drainage, or measurements. On 08/18/2026 at 01:11 PM laid in her bed as staff prepared her for wound care to her bottom. On 08/18/2026 at 01:25 PM, LN G stated that the wound care team was who actually does all the measurements and documents wound information. LN G stated he does wound care treatments as ordered and follows wound care when they come to the facility. On 08/19/2026 at 11:52 AM, Administrative Nurse D stated that the facility's policy was for wound measurements not to be done by facility staff but by wound care upon referral and evaluation. Administrative Nurse D stated that wounds of any type probably should be measured upon admission so they would have a baseline assessment to go by. The facility's "Pressure Ulcer Prevention" policy dated 02/13/2026 documented all admitted patients will be evaluated for risk of developing pressure ulcers and/or identification of current skin issues. Patient's will receive care consistent with professional standards of practice to prevent pressure ulcers and/or ensure patients do not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable. A patient with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. Patient with actual wounds should be evaluated for specific needs which may include but is not limited to: air mattress, specialty wheelchair cushion, multi-Podus Boot (lightweight plastic shell with a liner to help treat and prevent lower extremity disorders) (right, left, or bilateral), heels up, supplements as recommended by the dietician, and wound clinic referral for wounds greater than Stage 2 (partial-thickness skin loss into	F0686					

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F0686 SS = D	Continued from page 34 but no deeper than the dermis including intact or ruptured blisters). The documentation of ulcers will include a description of the wound (size, induration, color, drainage, odor, etc.), current interventions and treatments, as well as response to interventions and treatments. The Clinical Nurse Manager, or designee will examine ulcers weekly. Ulcers not responding to current treatments will be re-evaluated and changes made as appropriate. Referral to the physician and/or wound specialist should be initiated.	F0686					
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 observation, record review, and interview, the facility failed to ensure the safety and well-being of Resident (R) 60 while he was in bed and resulted in the falls. The facility failed to ensure staff followed fall interventions as requested by R60's family. Findings included: - R60's Electronic Medical Record (EMR) documented diagnoses of respiratory failure (when your lungs cannot move enough oxygen into your blood, or they cannot remove enough carbon dioxide from your blood), aspiration pneumonia (a lung infection that happens when you breathe food, liquid, vomit, or spit into your airways), vascular dementia (a decline in thinking skills caused by blocked or reduced blood flow to the brain), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).	F0689					

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F0689 SS = D	Continued from page 35 R60's "Admission Minimum Data Set (MDS)" was not completed as he admitted the facility on 08/13/2026. R60's "Care Area Assessments (CAA)" had not yet been completed. R60's Care Plan dated 08/14/2026 directed staff to be sure his call light was in reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance; to keep bed in the lowest position; place mattress on the floor next to the bed to reduce the risk of injury in the event of a fall; provide verbal reminders/cues to ask for assistance as needed. An intervention dated 08/15/2026 directed staff to add bolsters to the bed. An intervention dated 08/17/2026 directed staff to conduct scheduled safety checks at least every two hours and as needed. During rounds, assess him for toileting needs, pain/discomfort, positioning, hunger/thirst, and need for assistance; offer toileting, fluids, snacks, and other comfort measures as appropriate; ensure call light and personal items are within reach and maintain a safe, clutter-free environment. R60's "Admission Nursing Observation with pain interview" dated 08/13/2026 indicated a fall risk score of 15, which indicated he was a moderate risk for falls due to noncompliance. Goal: Patient will remain free from serious injury related to falls with appropriate interventions in place while maintaining patient's independence and rights, including the right to refuse interventions with appropriate informed decision making. Fall #1. A "Nursing" progress note in the EMR dated 08/14/2026 at 06:30 AM documented Date of fall: 08/14/2026, Time responded: 04:00; Location: Resident room; Position when found: Pt was lying on the floor mat beside his bed in supine position; Description: Patient was lying in bed prior to the fall. The bed was in lowest position, and floor mats were placed on each side of the bed. A touch call light was attached to his gown, which came off the wall when he slid from the bed to the floor mat, alerting the nurse aide. No injury noted. R60 was assisted back to bed by four staff members. Reported to provider and responsible party. Additional Notes: R60 is refusing to keep his oxygen on and literally getting it off his ears. He did not understand the need to have the oxygen on even after educating him.			F0689			

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F0689 SS = D	Continued from page 36 Fall #2. A "Fall" Progress note dated 08/15/2026 at 01:21 R60 was found sliding himself from the bed to the floor mat next to bed. R60 did not hit his head. No injury noted. His bed was in the lowest position. Neurological checks within normal limits. Left a message for the physician and DON. Fall #3. On 08/16/2026, R60's daughter came into the room shortly after noon to find him on the floor on the mat with his brief unfastened and fecal matter on the resident and the bed. The resident was not in reach of his call light. Fall #4 – On 08/17/2026 at 05:59 AM a "Fall Progress Note" in the EMR documented: Date of fall: 08/17/2026; Time responded: 05:42; Location: Resident room; Position when found: laying on the floor at the head of his bed on his back. Description: The resident had an unwitnessed fall onto the floor in his apartment. A cut to the left earlobe was observed and left earlobe was bleeding at the time of assessment. Neurological checks started. The resident was assisted to the bed by this writer and two Certified Nurse Aides (CNA). At the time of the fall the residents did not sleep during this shift and had been calling out during the night. The resident was last checked on by this writer to get a set of vitals related to a previous fall approximately 40 minutes prior to this fall being reported. At that time the resident was observed in his bed, falling mats down, call light within reach. How was patient moved after fall: A sling was placed underneath him as he is unable to ambulate and was lifted from the floor to the bed. Incident was reported to the provider and the responsible party. Fall#5 On 08/1at8/2026 at 02:59 AM, R60 was found in his room in the process of scooting from his bed to the floor mattress next to his bed. When resident was told to stop scooting further, he continued, and he sustained lacerations to his right knee and bilateral lower extremity (BLE) shins. He did not hit his head. Treatment was done for the right knee and BLE shins. Resident was alert to self. A message was left to the provider and director of nursing. R60's 08/18/2026 at 06:20 AM "Physician" note in the EMR documented: has had multiple falls since arriving at the facility per nursing - documented on 08/14/2026, 08/15/2026 and 08/17/2026. Mattresses have since been moved to the floor, which was noticed when entering his room this morning. He is sleeping at the time of exam and given recent reports of agitation and restlessness, was not awakened. Nursing has requested something for agitation; however, he was sensitive to meds while			F0689			

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F0689 SS = D	Continued from page 37 in the hospital, resulting in intubation (medical procedure where a flexible plastic tube is inserted through the mouth or nose into the windpipe to keep an airway open, deliver oxygen or anesthesia, or connect a patient to a breathing machine)(per report). As needed, hydroxyzine (an antianxiety medication- a medication used to calm and relax people) was ordered for now. The resident would benefit from a sitter if the family or facility was able to provide. His vital signs were stable, and he is afebrile. An "Interdisciplinary Team (IDT) Fall Review" note in R60's EMR on 08/18/2026 at 08:06 AM, documented: The date of fall was on 08/14/2026. Resident sustained no injury. Intervention initiated/care plan update at time of fall was for a mattress on the floor next to the bed. An "IDT Fall Review" note in R60's EMR dated 08/18/2026 at 08:12 AM documented: the date of fall was on 08/15/2026. No injury occurred. Intervention initiated/care plan updated at time of fall was bolsters to the bed, keep bed in the lowest position. An "IDT Fall Review" note in R60's EMR dated 08/18/2026 at 08:29 AM documented: the date of the fall was 08/17/2026. Resident had an injury of a skin tear to his left earlobe. Intervention initiated/care plan updated at time of fall with every two-hour checks and physician's evaluation of current medications On 08/19/2026 at 09:45 AM, the NFS was approached by R60's daughter with concerns regarding her father. R60's daughter voiced concern that the director of nursing had ensured and promised yesterday during care planning meeting that the thick blue mats would be placed on both sides of R60's bed. When she arrived at the facility at 06:30 AM today, those mats were not in place as requested. The daughter stated that there were brown, very thin mats on the floor. Facility staff had recommended that family stay with him all the time or to hire a sitter for him. R60's daughter voiced her frustration about that suggestion as she asked staff then what was their job/role in her dad's care. On 08/17/2026 at 10:54 AM, R60 was in his room and had supplemental oxygen on, multiple bruising noted to his left arm. R60's daughter was present in the room. Thick blue mats were present on the floor beside the bed. R60's daughter stated he has had numerous falls since being admitted on 08/13/2026, and she was concerned for his safety.			F0689			

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F0689 SS = D	Continued from page 38 On 08/19/2026 at 10:45 AM, R60 was observed in his bed with staff present in room. Brown thin mats were noted against the wall. No blue, thick mats were present in the room. Emergency medical services present to transport the resident to the hospital due to critical lab values. On 08/19/2026 at 02:15 AM, Administrative Nurse D and Consultant GG (Nurse liaison consultant and former DON) stated that R60 had been a difficult resident and had sustained numerous falls since his admission on 08/13/2026, and due to his cognition deficits, it had been harder for them to have appropriate interventions in place. R60's daughters had requested that the blue mats always be in his room, and they could not state why they were not in place or in the room this morning. Consultant GG went on to state that it had been recommended to the family to always be here to be with their father or that a paid sitter might be needed to ensure all fall preventive measures could be addressed and to avoid further injury. Management and staff were doing their best to have interventions in place that were specific and appropriate for R60. The facility's "Fall Prevention" policy dated 10/28/2025 documented 1. Upon admission, each patient will be evaluated for risk of falls utilizing the "Fall Risk Observation". 2. The observation assesses the patient's status in seven clinical areas: 1. Mental status 2. History of falls in the last 6 months 3. Ambulation / Elimination status 4. Vision status 5. Gait / Balance / Ambulation 6. Medications 7. Predisposing Factors 3. Based upon the calculated score, a fall risk level is selected 1. A score of 0-9 = Low risk 2. A score of 10-20 = Moderate risk	F0689					

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F0689 SS = D	Continued from page 39 3. A score of 21 or > = High risk 4. If the fall resulted in admission to the facility, regardless of score, the patient is a high risk 5. If the patient has had 2 or more falls in the past 30 days, regardless of score, the patient is a high risk 4. Based upon the calculated score, the "Fall Risk Protocol and Care Plan" will be completed and interventions initiated. 1. Low risk = 1 safety intervention 2. Moderate risk = 2 safety interventions 3. High risk = 3 safety interventions 5. Safety interventions may include but are not limited to: 1. Adaptive equipment 2. Bed in lowest position 3. Bolsters to bed 4. Don't leave unattended in the restroom 5. Environmental checks Q 4 hours 6. Fall mats 7. Motion sensor pad 8. Non-skid socks 9. Non-skid surface to recliner 10. Non-skid surface to wheelchair 11. Every 2 hour checks 12. Reacher 13. Toilet riser 14. Toileting program 15. Touch pad call light	F0689					

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F0689 SS = D	Continued from page 40 16. Visual sign(s) posted in room 6. The Admitting Nurse will be responsible for ensuring that interventions are initiated and communicated to appropriate staff for follow-through. 7. At any time, the assigned Licensed Nurse may initiate the use of additional safety interventions as a treatment order in Matrix based upon patient assessment. 8. The assigned Licensed Nurse will be responsible for ensuring safety interventions are in place as care planned and will initial the TAR indicating verification. 9. If a fall occurs in the facility an additional "Fall Risk Observation" will be completed by the Licensed Nurse. 10. An additional safety intervention will be initiated by the Licensed Nurse following a fall. 11. A care plan update will be completed by the Licensed Nurse 12. The fall will be reviewed with the IDT team.	F0689					
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate,	F0756					

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F0756 SS = D	Continued from page 41 written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the Consultant Pharmacist (CP) identified and reported that Resident (R) 1's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications lacked a Centers for Medicare and Medicaid (CMS) appropriate indication for use. Findings included: - 1. R1's Electronic Medical Record (EMR) documented diagnoses of metabolic encephalopathy (a broad term for brain dysfunction caused by an underlying systemic illness in the blood) and disorientation (state of mental confusion where a person loses their sense of direction, position, or awareness). R1's "Annual Minimum Data Set (MDS)" dated 06/18/2026 documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R1 required substantial/maximum assist to being dependent on staff for her cares. R1 received an antipsychotic and an antidepressant (a class of medications used to treat mood disorders). R1's "Psychotropic Care Area Assessment (CAA)" dated 06/25/2026 documented she received	F0756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/19/2026	
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY , OVERLAND PARK, Kansas, 66207		
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F0756 SS = D	Continued from page 42 psychotropic medications and was at risk for side effects. The care plan would be developed to monitor adverse effects and evaluate the medication response. R1's Care Plan directed staff she was taking medications with a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). She was on the antipsychotic medication Seroquel for management of mood disorders. Staff was directed to administer as directed and monitor for adverse effects. R1's "Orders" tab of the EMR documented an order dated 06/12/2026 for Seroquel 25 milligrams (mg) tablet at bedtime for delirium (sudden severe confusion, disorientation, and restlessness). This order lacked an appropriate indication for use of an antipsychotic medication. Review of the CP's Monthly Regimen Review for R1 for June and July 2026 revealed no irregularities had been noted. R1's EMR lacked documentation of a physician's rationale for the inappropriate indication along with a risk versus benefits review and evidence of non-pharmacological interventions that were attempted but unsuccessful. On 08/18/2026 at 11:30 AM, R1 was getting prepared to go to the dialysis (a procedure where impurities or wastes are removed from the blood) center for her scheduled treatments. On 08/19/2026 at 02:13 PM, Consultant GG stated that the pharmacist did do MRRs monthly and would make recommendations for residents that had been here over a month. Consultant GG stated she was aware some of the residents had been admitted from the hospital on an antipsychotic and the CP should identify and report when they are not used appropriately. For residents on antipsychotic medications, a referral for psychiatric evaluation may be initiated. The facility's "Chemical Restraint/Psychotropic Medication Management" policy documented each patient's drug regimen, will be free from unnecessary psychotropic medications. Patients who admitted receiving psychotropic medications, or have psychopharmacological medications initiated in house, will receive a comprehensive and ongoing evaluation of their current medication regimen. Evaluation will examine dosage, duplicate therapy,	F0756			

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F0756 SS = D	Continued from page 43 duration, adequate monitoring, indication for use, and adverse consequences, with consideration of risks and benefits in consultation with his/her physician. Within 7 days of admission to the facility, or initiation of a psychotropic medication, the Director of Nursing (DON), or designee, will complete a "Psychopharmacological Medication Review", notifying the physician, as appropriate, of any recommendations or concerns. Upon response of the physician, changes will be made per physician order. The "Psychopharmacological Medication Review" will evaluate each psychotropic medication for dosage, duplicate therapy, duration, adequate monitoring, indication for use, and adverse consequences. Psychopharmacological medications will also be reviewed by the consulting pharmacist, who may note any concerns in the Drug Regimen Review performed within 30 days of admission for each patient. Psychotropics in excessive dose and/or inadequate indication for use, will undergo a Gradual Dosage Reduction (GDR) within a timeframe consistent with current standards of practice unless clinically contraindicated and the rational of such documented by the patient's physician.	F0756					
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.	F0732					

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F0732 SS = C	Continued from page 44 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to display current daily nursing staff hour information. Findings included: - During the facility tour on 08/17/2026 at 08:00 AM, the daily nursing staff posting at the front desk had the date of 08/14/2026. On 08/18/2026 at 07:45 AM, the daily nursing staff posting at the front desk had the date of 08/17/2026. On 08/18/2026 at 08:00 AM, Administrative Staff A stated that the receptionist was responsible for the nursing staff posting when she arrived each morning. On 08/19/2026 at 08:20 AM, the daily nursing staff	F0732					

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F0732 SS = C	Continued from page 45 posting at the front desk had the date of -8/18/2026. The facility did not provide a policy for daily posted staffing upon request.	F0732			