STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175410	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH , BEL AIRE, Kansas, 67226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations 3171656, 3117689, and 3064973. The census was 150. The sample included 35 residents.	F0000		
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,	F0628		

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

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F0628 SS = E	Continued from page 2 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as 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 3 §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,	F0628		

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F0628 SS = E	Continued from page 4 the facility failed to provide Residents (R) 13,18, 40, 82, and/or their representatives with a written notification of transfer for facility-initiated transfers and a bed hold policy upon transfer to the hospital. The facility further failed to notify the long-term care ombudsman (LTCO) of transfers to the hospital. Findings included: - 1. Resident (R) 13's "Discharge Minimum Data Set" (MDS) dated 03/12/2026 documented a planned discharge to an acute hospital with a return anticipated. R13's "Entry MDS," dated 03/17/2026, documented a re-entry to the facility from an acute hospital. R13's "Discharge MDS, dated 04/07/2026, documented a planned discharge to an acute hospital with a return anticipated. R13's "Entry MDS, dated 04/10/2026, documented a re-entry to the facility from an acute hospital. On 08/25/2026 at 12:10 PM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R13. The facility was unable to provide the requested information regarding R13's transfers to the hospital. On 08/25/2026 at 12:10 PM, Administrative Staff A stated the Social Service Designee (SSD) was responsible for notifying the ombudsman when R13 went to the hospital and verified the LTCO had not been provided. Administrative Staff A stated the bed hold policy is sent with R13; the representative had been notified by phone regarding why R13 was transferred to the hospital and the bed hold policy on the above dates. Administrative Staff A stated the facility had not received a signed copy of the bed hold policy. 2. R82's "Discharge MDS, dated 01/16/2026, documented a planned discharge to an acute hospital with a return anticipated. R82's "Entry MDS, dated 01/20/2026, documented a re-entry to the facility from an acute hospital. R82's "Discharge MDS, dated 03/01/2026, documented a planned discharge to an acute hospital with a return anticipated. R82's "Entry MDS, dated 03/05/2026, documented a re-entry to the facility from an acute hospital.	F0628		

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F0628 SS = E	Continued from page 5 On 08/25/2026 at 12:10 PM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R82. The facility was unable to provide the requested information regarding R82's transfers to the hospital on the above dates. On 08/25/2026 at 12:10 PM, Administrative Staff A stated the Social Service Designee (SSD) was responsible for notifying the ombudsman when R82 went to the hospital and verified the LTCO had not been notified since December 2025 because they had hired a new SSD, and she was unaware she was to provide the ombudsman notifications. Administrative Staff A stated the bed hold policy is sent with R82, and the representative was notified by phone regarding why she was transferred to the hospital and the bed hold policy on the above dates. Administrative Staff A stated the facility does not receive a signed copy. 3.R41s "Discharge MDS, dated 04/26/2026, documented a planned discharge to an acute hospital with a return anticipated. R41's "Entry MDS, dated 05/01/2026, documented a re-entry to the facility from an acute hospital. R41's "Discharge MDS, dated 06/01/2026, documented a planned discharge to an acute hospital with a return anticipated. R41's "Entry MDS, dated 06/04/2026, documented a re-entry to the facility from an acute hospital. On 08/25/2026 at 12:10 PM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R41. The facility was unable to provide the requested information regarding R4's transfers to the hospital on the above dates. On 08/25/2026 at 12:10 PM, Administrative Staff A stated the Social Service Designee (SSD) was responsible for notifying the ombudsman when R41 went to the hospital and verified the LTCO had not been notified since December 2025 because they had hired a new SSD, and she was unaware she was to provide the ombudsman notifications. Administrative Staff A stated the bed hold policy is sent with R41, and the representative was notified by phone regarding why she was transferred to the hospital and the bed hold policy on the above dates. Administrative Staff A stated that the facility does not receive a signed copy.	F0628		

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F0628 SS = E	Continued from page 6 4.R40 “Discharge MDS, dated 11/18/2025, documented a planned discharge to an acute hospital with a return anticipated. R40’s “Entry MDS, dated 07/24/2026, documented a re-entry to the facility from an acute hospital. R40's “Discharge MDS, dated 11/18/2025, documented a planned discharge to an acute hospital with a return anticipated. R40’s “Entry MDS, dated 11/21/2025, documented a re-entry to the facility from an acute hospital. On 08/25/2026 at 12:10 PM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R40. The facility was unable to provide the requested information regarding R40 transfers to the hospital on the above dates. On 08/25/2026 at 12:10 PM, Administrative Staff A stated the Social Service Designee (SSD) was responsible for notifying the ombudsman when R40 went to the hospital and verified the LTCO had not been notified since December 2025 because they had hired a new SSD, and she was unaware she was to provide the ombudsman notifications. Administrative Staff A stated the bed hold policy is sent with R40, and the representative was notified by phone regarding why she was transferred to the hospital and the bed hold policy on the above dates. Administrative Staff A stated that the facility does not receive a signed copy. 5.R18s “Discharge MDS, dated 04/23/2026, documented a planned discharge to an acute hospital with a return anticipated. R18’s “Entry MDS, dated 04/30/2026, documented a re-entry to the facility from an acute hospital. R18's “Discharge MDS, dated 04/11/2026, documented a planned discharge to an acute hospital with a return anticipated. R18’s “Entry MDS, dated 04/19/2026, documented a re-entry to the facility from an acute hospital. R18's “Discharge MDS, dated 06/26/2026, documented a planned discharge to an acute hospital with a return anticipated. R18’s “Entry MDS, dated 06/27/2026, documented a re-entry to the facility from an acute hospital.	F0628		

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F0628 SS = E	Continued from page 7 On 08/25/2026 at 12:10 PM, the bed hold, written notification of transfer, and LTCO notification were requested from the facility for R18. The facility was unable to provide the requested information regarding R18 transfers to the hospital on the above dates. On 08/25/2026 at 12:10 PM, Administrative Staff A stated the Social Service Designee (SSD) was responsible for notifying the ombudsman when R18 went to the hospital and verified the LTCO had not been notified since December 2025 because they had hired a new SSD, and she was unaware she was to provide the ombudsman notifications. Administrative Staff A stated the bed hold policy is sent with R18, and the representative was notified by phone regarding why she was transferred to the hospital and the bed hold policy on the above dates. Administrative Staff A stated that the facility does not receive a signed copy. The facility's "Bed-Holds and Returns Policy," revised March 2017, documented prior to a transfer, written information would be given to the residents and the resident representatives that explains in detail: The rights and limitations of the resident regarding bed-holds; The reserve bed payment policy as indicated by the state plan (Medicaid residents); The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and The details of the transfer (per the transfer notice). Upon request, the facility failed to provide a policy regarding LTCO notification.	F0628		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are	F0609		

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F0609 SS = D	Continued from page 8 reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to report to the state agency an injury of unknown origin when one resident, Resident (R)129, was found in his room with a laceration (cut) to his right eye and inner right eyebrow. Findings included: - The Electronic Medical Record (EMR) for R129 recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, and lack of coordination. R129's "Admission Minimum Data Set" (MDS), dated 06/03/2026, documented R129 had severely impaired cognition. R129 required partial staff assistance with toileting hygiene, showers, and putting on his shoes. R129 had no functional impairment, wandered one to three days, and was independent with transfer, mobility, and ambulation, and had no falls. The "Significant Change MDS," dated 07/24/2026, documented R129 had severely impaired cognition. R129 required substantial staff assistance for all activities of daily living. R129 had no functional impairment, had one non-injury fall, and was independent with mobility and ambulation. The "Fall Risk Assessments," dated 05/28/2026 and	F0609		

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F0609 SS = D	Continued from page 9 07/20/2026, documented R129 was at risk for falls. The 05/28/2026 “Care Plan” documented the following interventions for R129’s falls: 05/28/2026- Encourage the use of non-skid footwear during ambulation and transfer, ensure adequate lighting during waking hours. The bathroom light or nightlight may be left on during sleep hours. Ensure his call light was within reach while in his room unsupervised. Encourage R129 to use the call light to alert staff for assistance, and staff are to ensure a safe environment. 06/04/2026- Staff are to observe R129 for mobility issues and update the charge nurse as indicated. 06/08/2026- Keep R129’s bed in the lowest position when he was in bed. 07/05/2026 – R129 was sent to the Emergency Room and received stitches for his laceration to his face. The care plan lacked further direction for staff to prevent further falls. The “Fall Investigation,” dated 07/05/2026 at 05:30 AM, documented staff found R129 in his room rubbing his bathroom curtain and bleeding on his face. R129 had a cut under his right eye and on the right inner eyebrow. R129 had impaired cognition and could not say what happened or what the point of impact was. The investigation further documented that R129 had been toileted one hour before the event and ambulated stooped over. The investigation recommendation was to send him to the emergency room for treatment and to continue physical therapy. The “Nurse’s Note,” dated 07/05/2026 at 10:23 AM, documented R129 returned to the facility with family and received less than five stitches that were to be removed in one week. R129 had a computed tomography (CT scan-a test that uses X-ray technology to make multiple cross-sectional views of organs, bones, soft tissue, and blood vessels), and the results were negative. Upon request, the facility was unable to provide evidence that the facility reported the injury of unknown origin to the state agency. On 08/25/2026 at 12:48 AM, R129 stood up from the dining room table and walked with Certified Nurse Aide (CNA) N to his room. R129 walked hunched over and held CNA N’s hand as they walked. On 08/26/2026 at 10:20 AM, Certified Medication	F0609		

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F0609 SS = D	Continued from page 10 Aide (CMA) R stated R129 was independent with transfers, but staff usually walk with him and try to make sure they know where he is because he walked hunched over. On 08/26/2026 at 10:30 AM, Licensed Nurse (LN) G stated R129 was a fall risk due to cognition and that he walked hunched over. Staff try to give him fidget toys for his tactile stemming (performing repetitive self-regulatory touch behaviors, like rubbing fabrics or tapping surfaces). On 08/26/2026 at 01:56 PM, Administrative Nurse D stated that he had not reported the injury of unknown origin to the state agency because even though R129 could not tell them what happened, they did not feel there was any abuse or neglect. Administrative Nurse D further stated that she was unsure if there had been an update to R129's care plan after the incident. The facility's "Abuse, Neglect & Exploitation Prevention and Prohibition" policy, dated 10/2022, documented the residents have the right to be free from abuse, neglect & exploitation. This includes injuries of unknown origin. These would be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management.	F0609		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F0656		

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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
F0656 SS = D	Continued from page 11 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for Resident (R) 6 regarding his nutritional status. Finding included: - R6's Electronic Medical Record (EMR) included diagnoses of acute pulmonary (lung) edema (swelling resulting from an excessive accumulation of fluid in the body tissues), muscle weakness, lack of coordination, dysphagia(swallowing difficulty) following cerebral infarction (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and gastroparesis (condition where food empties from stomach into the small intestine much slower than normal). R6's "Admission Minimum Data Set" (MDS) dated 07/24/2026 documented R6 had severe cognitive	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175410	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2026

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F0656 SS = D	Continued from page 12 impairment, no delirium, and behaviors. R6 had functional range of motion in both sides of lower extremities and used a wheelchair and required substantial/maximal assistance with eating, functional abilities, and mobility. The MDS further documented R6 had coughing or choking during meals or when swallowing medications and received 51 percent (%) of calories through a feeding tube. R6 also received physical, occupational, and speech therapy. R6's Nutritional Care Area Assessment", dated 07/26/2026, documented triggers secondary to swallowing issues, mechanically altered diet, diabetes (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), renal failure, and dysphagia. The risk factors included aspiration, weight instability, and impaired skin integrity. A care plan will be initiated to improve dietary and hydration status, monitoring labs, weight, and dietary/fluid intake. The "Feeding Tube Care Area Assessment" dated 07/26/2026 documented secondary to the use of a feeding tube via tube for maintenance of nutritional/hydration status. Contributing factors included dysphagia, malnutrition, and recent acute medical condition and decline. A care plan will be developed to improve nutritional and hydration status, monitor labs/weights, monitor patency of feeding tube, and dietary/fluid intake. On 08/17/2026, upon review of R6's Care Plan, it lacked a nutritional focus. The "Nutritional Progress Note" dated 08/04/2026 at 12:59 PM recorded R6's weight was down 3.2% since admission. The diet of consistent carbohydrates (CCHO) with mechanical soft textures, to offer a supplement three times a day. R6 also had orders for Osmolite (liquid nutritional supplement) 1.5 at 50 milliliters (ml) as needed. R6 was further documented as eating 75% on average, had an order to discontinue the feeding tube, and had supplements in place for added nutrition. The "Nutritional Progress Note" dated 08/25/2026 at 01:35 PM, R6's weight was down 1.9% this week. Diet is NAS (No Added Salt) CCHO with regular textures. R6 was offered a supplement three times a	F0656		

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F0656 SS = D	Continued from page 13 day and a snack of choice daily. The diet texture was upgraded on 08/21/2026 from mechanical soft to regular. On 08/25/2026 at 08:41 AM, R6 was brought to the dining room and provided with breakfast. R6 was encouraged to eat by another resident who also cut up his pancake and moved R6's plates and glasses for him to reach. R6 ate 75% of the meal and dropped 25% on the table and floor. On 08/26/2026 at 09:38 AM, Consultant GG reported that R6's swallowing ability had improved. On 08/26/2026 at 11:56 AM, Licensed Nurse (LN) H reported R6 had the ability to eat and drink on his own, and the staff was to encourage R6 to eat. On 08/26/2026 at 02:00 PM, Administrative Nurse D verified the Care Plan lacked a nutritional focus due to resolution of the feeding tube. Administrative Nurse D reported that a revision had now been added. The facility's "Comprehensive Person-Centered Care Plans" policy, dated 12/2016, documented that the comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, describe any specialized services, and incorporate identified problem areas.	F0656		
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:	F0689		

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F0689 SS = D	Continued from page 14 Based on observation, record review, and interview, the facility failed to ensure an environment free from chemicals and hazards for seven cognitively impaired, independently mobile residents who resided on Chapel Hall and failed to update the care plan for Resident (R) 129, who had a fall with injury and lacked interventions after the fall. Findings included: - On 08/25/2026 at 07:55 AM, observation revealed an unlocked metal blanket warmer, approximately 22 inches (in) wide by 35 inches tall with the door being unlocked and the temperature reading on the unit was 128 degrees Fahrenheit (F). Continued observation revealed the unlocked warmer had two metal racks inside that stored blankets, and the metal shelves were warm to the touch. Continued observation revealed twelve residents were at the adjacent dining room tables eating breakfast, and some ambulating independently down the hall. On 08/25/2026 at 8:5 AM, Administrative Nurse D verified the blanket warmer was 128 degrees F and was an accident hazard and verified she would get the operational manager to move it to a secure location away from the residents who were able to easily access the warmer. The facility's "Hazardous Areas, Devices and Equipment" policy, dated July 2024. documented all hazardous areas, devices and equipment in the facility would be identified and addressed appropriately to ensure residents' safety and mitigate accident hazards to the extent possible. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Environmental hazards include equipment and devices that are left unattended or are malfunctioning, open areas or items that should be locked when not in use, and unsafe exposure to heating elements or water temperatures. The policy documented that any element of the resident's environment that has the potential to cause injury and that is accessible to the vulnerable residents is considered hazardous. - The Electronic Medical Record for R129 recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, and lack of coordination.	F0689		

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F0689 SS = D	Continued from page 15 R129's "Admission Minimum Data Set" (MDS), dated 06/03/2026, documented R129 had severely impaired cognition. R129 required partial staff assistance with toileting hygiene, showers, and putting on his shoes. R129 had no functional impairment, wandered one to three days, and was independent with transfer, mobility, and ambulation, and had no falls. The "Significant Change MDS," dated 07/24/2026, documented R129 had severely impaired cognition. R129 required substantial staff assistance for all activities of daily living. R129 had no functional impairment, had one non-injury fall, and was independent with mobility and ambulation. The "Fall Risk Assessments," dated 05/28/2026 and 07/20/2026, documented R129 was at risk for falls. The 05/28/2026 "Care Plan" documented the following interventions for R129's falls: 05/28/2026- Encourage the use of non-skid footwear during ambulation and transfer, ensure adequate lighting during waking hours. The bathroom light or nightlight may be left on during sleep hours. Ensure his call light was within reach while in his room unsupervised. Encourage R129 to use the call light to alert staff for assistance, and staff are to ensure a safe environment. 06/04/2026- Staff are to observe R129 for mobility issues and update the charge nurse as indicated. 06/08/2026- Keep R129's bed in the lowest position when he was in bed. 07/05/2026 – R19 was sent to the Emergency Room and received stitches for his laceration to his face. The "Fall Investigation," dated 07/05/2026 at 05:30 AM, documented staff found R129 in his room rubbing his bathroom curtain and bleeding on his face. R129 had a cut under his right eye and on the right inner eyebrow. R129 had impaired cognition and could not say what happened or what the point of impact was. The investigation further documented R129 had been toileted one hour before the event and ambulated stooped over. The investigation recommendation was to send him to the Emergency room for treatment and to continue physical therapy. The "Nurse's Note," dated 07/05/2026 at 10:23 AM, documented R129 returned to the facility with family and received less than five stitches that were to be removed in one week. R129 obtained computed	F0689		

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F0689 SS = D	Continued from page 16 tomography (CT scan-a test that uses X-ray technology to make multiple cross-sectional views of organs, bones, soft tissue, and blood vessels), and the results were negative. On 08/25/2026 at 1248 AM, R129 stood up from the dining room table and walked with Certified Nurse Aide (CNA) N to his room. R129 walked hunched over and held CNA N's hand as they walked. On 08/26/2026 at 10:20 AM, Certified Medication Aide (CMA) R stated he was independent with transfers, but staff usually walk with him and try to make sure they know where he is because he walked hunched over. On 08/26/2026 at 10:30 AM, Licensed Nurse (LN) G stated he was a fall risk due to cognition and that he walked hunched over. Staff tried to give him fidget toys for his tactile stemming (performing repetitive self-regulatory touch behaviors, like rubbing fabrics or tapping surfaces). On 08/26/2026 at 01:56 PM, Administrative Nurse D stated that R129 had not reported the injury of unknown origin to the state agency, as even though R129 could not tell them what happened, they did not feel there was any abuse or neglect. Administrative Nurse D further stated that she was unsure if there had been an update to his care plan after the incident. The facility's "Falls-Clinical Protocol," dated 05/2022, documented the nurse would identify individuals with a history of falls and risk factors for falling. The nurse would chart high-risk status and interventions on the care plan. Based on assessments, the team would identify pertinent interventions to try to prevent subsequent falls. The staff would monitor and document the individual's response to interventions intended to reduce falling every shift for 72 hours post-fall.	F0689		
F0742 SS = D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and	F0742		

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F0742 SS = D	Continued from page 17 services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R)123. Findings included: - R123's Electronic Health Record (EHR) revealed diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress,) intellectual disability (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life,) and schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R123's "Quarterly Minimum Data Set" (MDS), dated 07/27/2026, recorded R123 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS indicated the resident required a wheelchair for mobility. R123's "Self-Care Deficit Care Plan," dated 07/23/2026, documented the resident did not like to sleep in her room and preferred to sleep in a recliner in the commons area. The care plan documented the resident had experienced both physical assault and rape from a relative and a lost her sister from suicide. The care plan directed staff to observe R123 for specific triggers for R123 to avoid re-traumatization, avoid TV shows or movies that depict violence or sexual assault. The care plan directed staff to offer emotional support, mediations, deep breathing, prayer and calming music. R123's "Behavioral Care Plan" dated 07/23/2026, documented R123 had behavioral problems and staff would explain all procedures to R123 before starting and allow R123 to adjust to changes. The care plan documented staff would intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove	F0742		

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F0742 SS = D	Continued from page 18 from the situation, and take to an alternate location. A progress note dated 08/07/2026 at 04:17 AM, documented R123, was seen in her room with a fan cord wrapped around her body. Staff asked R123 what was wrong, and she stated, “I just want someone to sit in my room with me.” The notes documented R123 had been sitting in a recliner in the living room but would not allow staff to toilet her every two hours, so she was sleeping in her bed at the time. On 08/07/26026 at 04:31 AM, documented R123 was found in her room tearing off her colostomy bag, and feces was observed on her hands and all over her stomach. The notes recorded R123 was cleaned up by the nurse and a new bag attached. R123 was taken to the dining room for increased supervision and given a snack and drink. The “Late Entry” Nurses Note (entered in the EHR on 08/25/2026 at 03;03 PM) documented the nurse manager removed R123’s fan after reading the nurse’s note stating R123 wrapped the fan cord around her body. The nurse manager documented that she spoke with the nurse that was working when the incident occurred and the nurse stated R123 wrapped the fan cord around her arm. On 08/07/2026 at 12:11 PM, the Nurse Practitioner progress note documented the resident was seen for hypotension and weakness and noted the resident had wrapped a fan cord around her body and pulled off her colostomy bag. The note documented R123 stated she was her own decision maker and had no guardian and no known family. The nurse practitioner documented R123 lacked the capacity to act as her own decision maker and a guardian was obtained. The note documented a message was sent by the nurse manager to have R123 seen by the psychiatric nurse practitioner. R123's clinical record lacked evidence or documentation from social service staff regarding resident the incident or her behaviors. The EHR lacked evidence of staff follow-up or monitoring of psychosocial status post event. On 08/26/2026 at 10:00 AM, observation revealed R123 sat in her wheelchair and was watching TV.	F0742		

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F0742 SS = D	Continued from page 19 R123 was dressed in street clothes and had nicely groomed hair. On 08/25/2026 at 02:30 PM, Administrative Nurse D verified the documentation on the incident on 08/07/2026 was when she was on vacation and stated she had talked to the nurse manager about the incident after she pulled the 24-hour report and read the nurses' notes. Administrative Nurse D verified the nurse manager contacted the provider who saw the resident at the facility a few hours later. Administrative Nurse D verified no immediate actions were put in place after the resident was observed with the fan cord around their body. Administrative Nurse D verified the Nurse Practitioner saw R123 on 08/11/2026 and determined the resident did not have any thoughts of self-harm and the fan was placed back in R123's room. The facility's, "Trauma Informed Care" policy, dated March 2019, documented the policy would guide stave in appropriate and compassionate care specific to individuals who have experienced trauma. The policy documented the facility supports a culture of emotional well-being and physical safety for residents, staff, and visitors. The policy documented trauma-informed care is culturally sensitive and person-centered. The caregivers are taught strategies to help eliminate, mitigate, or sensitively address a resident's triggers. Staff would establish an environment of physical safety, such as a well-lit entrance and parking lots, and security system personnel. The policy documented that the facility would develop an organizational culture that supports trauma-informed care and use trauma informed principals in strategic planning. The policy documented to include trauma-informed care as part of the Quality Assurance and Performance Improvement so that needs and problem areas are identified and addressed. The facility would evaluate trauma-informed practices as part of the facility assessment.	F0742		