

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175180		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/17/2026	
NAME OF PROVIDER OR SUPPLIER OVERLAND PARK POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5211 W 103RD STREET , 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 3194230, 3193145, 3188537, 3183578, 3194175, 3186671, 3181695, 3181706, 3133227, 3117591, and 3104776. The census was 135. The sample included 27 residents.			F0000			
F0730 SS = F	Nurse Aide Perform Review – 12Hr/Year In- service CFR(s): §483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure the five Certified Nurse Aides (CNAs) staff reviewed had a yearly performance evaluation completed. Findings included: - A review of the facility's staffing list revealed that the following CNAs were employed with the facility for more than 12 months and all lacked a yearly performance evaluation: CNA P, hired 06/30/2025, had no yearly performance evaluation upon request. CNA Q, hired 04/08/2025, had no yearly performance evaluation upon request. CNA MM, hired 07/15/2024, had no yearly performance evaluation upon request. CNA NN, hired 04/01/2025, had no yearly performance evaluation upon request.			F0730			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0730 SS = F	Continued from page 1 CNA OO, hired 11/18/2024, had no yearly performance evaluation upon request. On 09/16/2026 at 02:25 PM, Administrative Nurse D verified the five CNAs (listed above) did not have a yearly performance evaluation completed. She stated it was a group effort to ensure the yearly performance evaluations were completed. Administrative Nurse D stated Human Resources would be tracking the yearly performances going forward. The facility's "Performance Evaluations" policy, revised 06/2010, documented that the job performance of each employee would be reviewed and evaluated at least annually.			F0730			
F0804 SS = F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure food was served at palatizing temperatures and failed follow nutritionally approved recipes during preparation of the facility's puree-based meals. Findings included: - On 09/15/2026 at 07:35 AM, during the initial tour of the kitchen, the review of the food temperature log for breakfast on 09/15/2026 lacked recorded food temperatures. On 09/15/2026 at 08:23 AM, Certified Nurse Aide (CNA) YY carried Styrofoam room trays to be delivered. The food she prepared to serve was temperature-checked, and the sausage patties were 71 degrees Fahrenheit (F); the pancakes were 70 degrees F, and the cream of wheat was 77 degrees F. The orange juice was 50 degrees F. CNA YY verified the temperatures were not a safe holding or			F0804			

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F0804 SS = F	Continued from page 2 palatable serving temperature. She stated she was unsure how to proceed as the staff had been instructed not to use the microwave to heat up resident food items. CNA YY carried the Styrofoam container back to a room off the nurse's station, then reappeared and delivered the resident's room tray. On 09/15/2026 at 08:36 AM, Resident (R) 110 stated the food was always cold. On 09/15/2026 at 08:59 AM, R24 stated the food is often served cold. On 09/15/2026 at 09:07 AM, R122 stated she did not like the food at all; it was served cold, and often she did not even know what it was. On 09/15/2026 at 09:30 AM, R80 stated the food was horrible, and she would not eat it. On 09/16/2026 at 10:40 AM, Dietary Staff EE placed seven servings of cooked roast beef into the food processor bowl, then she added an unmeasured amount of beef broth into the food processor with the cooked roast beef. Dietary Staff EE added an unmeasured amount of beef broth to the cooked roast beef in the food processor two more times. On 09/15/2026 at 07:55 AM, Dietary Staff CC stated the food temperatures had not been obtained before seven of the food carts had been served to the residents. On 09/16/2026 at 10:55 AM, Dietary Staff CC stated Dietary Staff EE should have followed the recipe to ensure they maintained the nutritional value of the food. On 09/16/2026 at 11:05 AM, Dietary Staff BB stated staff should always follow the recipe to maintain the nutritional value of the food. She expected the food temperatures to be taken prior to being served to the residents. The facility's undated "Food Preparation and Service" policy documented that food and nutrition services employees would prepare, distribute, and serve food in a manner that complied with safe food handling practices.			F0804			
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.			F0812			

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F0812 SS = F	Continued from page 3 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to store and prepare food in the one facility kitchen under sanitary conditions to prevent food borne illnesses. Findings included: - Observation of the kitchen on 09/15/2026 at 07:28 AM revealed the following areas of concern: 1. The floor had debris and was sticky throughout. 2. Staff EE stated that at 0732, staff did not temperature-check breakfast foods, and multiple trays had already been sent out for consumption. Staff CC was advised to temp food at surveyor advisement. 3. The walk-in refrigerator had missing temperatures for September 13 and 14. 4. The walk-in freezer had missing temperatures for September 13 and 14. 5. Observation of the walk-in refrigerator revealed no use-by date on any refrigerator items. There were breaded cutlets in Ziploc bags that had no label at all and no dates; a red mystery sauce in a container labeled mixed fruit with no dates. There were	F0812					

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F0812 SS = F	Continued from page 4 single-serve butter packets on the floor and cooked chicken breast patties in Ziploc bags with no date. 6. The ice scoop for the ice machine was lying on the sink beside the ice machine. 7. There was dried food debris in the sink that had what appeared to be a tablet of medication in it. 8. There was a broken/missing tile under the dishwasher; the floor grate was broken and had fallen down into the floor drain. 9. There were used gloves on the floor in the mop closet along with other kitchen trash. 10. There were multiple missing baseboards near the dry food pantry. 11. There were multiple cases of food stacked directly on the floor in the middle of the dry pantry. 12. There was an unsealed cake mix, open without an open and use-by date, inside the pantry. During an observation on 09/16/2026 at 08:15 AM, review of the "Temperature Monitoring Form 3-Compartment High Temperature" for 09/2026 lacked documentation of recorded water temperatures for the three-sink dishwashing water (13 days) from 09/03/2026 to 09/15/2026. During an interview on 09/16/2026 at 11:15 AM, Dietary Staff BB stated she expected the food to be labeled and dated when opened and placed into the refrigerator or freezer. She said she had noticed there were no water temperatures logged since 09/02/2026 and confirmed the water should be checked at every meal service. The facilities policy "Food Preparation and Service," with no date, included: Food preparation staff adhere to proper hygiene and sanitization practices to prevent the spread of foodborne illnesses.	F0812					
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and	F0851					

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F0851 SS = F	Continued from page 5 contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule.	F0851					

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F0851 SS = F	Continued from page 6 The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ). Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year 2026, Quarter 3 (04/01/2026 to 06/30/2026) indicated that the facility triggered for excessively low weekend staffing and a one-star staffing rating. Review of the daily posted nursing hours from 03/01/2025 through 09/15/2026, and the working schedules from 04/01/2026 to 06/30/2026, provided by the facility, revealed no evidence of low weekend staffing. On 09/16/2026 at 11:10 AM, Administrative Staff A stated that the facility staffed the same number of staff on the weekend as they did during the week. He stated that for any call-ins or staff shortages, the facility used agency staff. He stated the reason that triggered low weekend staffing would have been an error in reporting of information. The facility's "Reporting Direct Care Staffing Information (Payroll-Based Journal)" policy, last revised 08/2022, documented that direct care staffing information is reported electronically to Centers for Medicare & Medicaid Services (CMS) through the Payroll-Based Journal system.			F0851			
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her			F0584			

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F0584 SS = E	Continued from page 7 personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews, the facility failed to ensure a safe, sanitary, homelike environment in residents' living areas throughout the facility. Findings included: - On 09/15/2026 at 07:30 AM, observation of the first-floor hallway near the elevators and the dining room revealed visibly soiled floors with large patches of sticky areas causing shoes to stick to the floor. On 09/15/2026 at 07:29 AM, observation in the Activity Room revealed the following: Activity Staff Z removed a large convection oven	F0584					

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F0584 SS = E	Continued from page 8 from the counter next to the hand-washing sink. An electric skillet remained on the counter. The inside of the skillet had dried food debris and a dirty spoon in it. Under the sink, there was an aerosol bottle of Ant/Roach Killer and various other cleaning chemicals. In the cabinet above the counter, there was a large bottle of Mrs. Dash seasoning. The lid was open, and the contents were exposed to air. The open date marked on the bottle read 08/11/2025. There was an open bottle of rainbow sprinkles with the contents exposed to air; there was no open date. The bottle had debris around the opening, and the bottle was soiled and sticky. There was a Ziplock bag of powder with sprinkles inside a larger Ziplock bag. The bags were unlabeled and undated. There was a Ziplock bag of white powder labeled Flour with an open date of 08/01/2025. There was a container of black pepper with the lid broken and open, exposing the contents to air. The lid also had food debris stuck on it. There was a half-full container of cream cheese ready-to-eat frosting. The frosting was dried around the edges. There was no open date. The container was labeled by the manufacturer with instructions to store unused frosting in the refrigerator after opening. There was an opened bag of powdered sugar with no date and an opened bag of flour stored in a Ziploc bag. The manufacturer's label on the flour listed a use-by date of 11/12/2022. There was a large popcorn popper with a pile of unpopped kernels as well as old, dried popcorn and skins in the tray under the popping well. The handwashing sink did not have any paper towels or a mechanism to dry hands after washing. On 09/15/2026 at 07:41 AM, observation in the first-floor dining room adjacent to the smoking area revealed an oxygen tank lying on the floor, not stored in a stand. On 09/15/2026 at 07:46 AM, observation in the unlocked Clean Utility room on the second floor	F0584					

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F0584 SS = E	Continued from page 9 revealed several open packages of incontinence briefs stored on the bottom of the open cabinet. There were also stacks of incontinence briefs outside of the package on the bottom shelf. The room contained two oxygen tanks, approximately half full, both on rolling stands. The handwashing sink lacked paper towels or a mechanism to dry hands after washing. On 09/15/2026 at 07:53 AM, observation of the second-floor shower room revealed a shower stall with broken molding and tile around the base. There was black staining on the grout/surface around the molding. The second stall had a piece of the light fixture missing, exposing the inner case. The last shower stall was out of order and was used to store equipment. There was a cabinet with the upper shelf broken, unattached, and hanging down inside the cabinet. Under the broken shelf was another with a pair of dry, crusted socks and a red hairbrush, full of strands of hair of varying colors. The brush was not labeled. The room also had a Sharps box (container to dispose of needles and sharp implements after use) case mounted on the wall but with no actual Sharps box in it. There was a used safety razor inside the case. On 09/15/2026 at 08:01 AM, observation outside the Janitor Office on the second floor revealed the baseboard had been removed but not replaced, leaving an unclean and unsanitizable surface exposed. Next to the Janitor Office on the 200 halls, there was a highbacked wheelchair in the hall. The chair has food debris on the cushion and arm rests. The right arm rest had cracked vinyl exposing the foam underneath. On 09/15/2026 at 08:08 AM, observation revealed CNA YY delivered room trays to residents on the second floor. Further observation revealed all the trays were Styrofoam, the food items were served inside Styrofoam boxes, and all eating utensils were white plastic. On 09/15/2026 at 08:23 AM, hot water temperatures were assessed in R40's room and found to be 78 degrees Fahrenheit (F); in R42's room, the hot water temperature was 56 degrees F. On 09/15/2026 at 08:30 AM, observation of the second-floor conference revealed staff lunch bags, cups, and other personal items were on a table. Opposite the table, there were wheelchairs and other equipment stored along the wall. One chair had a deflated low air loss mattress with a pump that was visibly soiled with an unknown brown substance.			F0584			

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F0584 SS = E	Continued from page 10 On 09/15/2026 at 08:35 AM, a visibly soiled full-body mechanical lift sat in the 300 halls. The lift was tagged with a green tag, which indicated it was last cleaned on 02/06/2026. On 09/15/2026 at 08:44 AM, observation on the 300 halls revealed a sit to stand lift stored in the hallway. The lift was visibly soiled with dirt and debris and had a lift sling draped over the top if it. On 09/15/2026 at 08:47 AM, observation of the second-floor TV Room attached to the dining room revealed an unlabeled, unmarked bottle of yellow liquid in the unlocked lower cabinet by the handwashing sink. The sink had a thick coating of grime in it, and the drain appeared to be partially obstructed as the water drained out very slowly. On 09/15/2026 at 01:12 PM, observation on the locked unit dining area revealed a 10–15-inch area that had the sub-material exposed and was visibly dirty. On 09/15/2026 at 12:41 PM, observation in the second-floor dining room attached to the TV room revealed multiple flies and gnats present. A fly landed on an unlidded cup sitting on the table. On 09/16/2026 at 08:45 AM, observation in R44's room revealed the bathroom call light did not have a pull string to activate it. On 09/16/2026 at 11:52 AM, the carpet on the 300 hall, close to the nurse's station, was sticky and had dark brown and white stains. On 09/15/2026 at 08:36 AM, R110 stated the facility had no hot water for almost two weeks but said it was fixed now. On 09/15/2026 at 09:15 AM, R44 stated sometimes the water is not warm enough for showers. She stated she had stopped showering because of the water temperatures. On 09/15/2026 at 07:42 AM, Activity Staff verified the Activity Room observations and stated the large convection oven was used to make cookies. She stated it should be cleaned and stored safely when not in use. Activity Staff Z also confirmed the food items were not stored in a sanitary manner and began removing the items for disposal. On 09/15/2026 at 07:53 AM, Certified Nurse Aide (CNA) XX stated she did not know how long the			F0584			

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NAME OF PROVIDER OR SUPPLIER OVERLAND PARK POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5211 W 103RD STREET , OVERLAND PARK, Kansas, 66207			
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F0584 SS = E	Continued from page 11 shower room stall and cabinet had been broken. She also stated she thought that the whirlpool tub was also out of order but then went on to say it might work, but she was uncertain since no one ever used it. CNA XX said the nurses were responsible for replacing the Sharps containers. She said she did not know who the socks and hairbrush belonged to but confirmed that personal hygiene items like hairbrushes should be marked with the resident's name to whom they belonged. On 09/15/2026 at 08:24 AM, CNA YY stated all the residents on the unit were served on Styrofoam because the dishwasher had been broken for almost a month. On 09/15/2026 at 08:47 AM, Housekeeping Staff KK retrieved the bottle of yellow liquid and stated she did not know what it was but said it looked like their disinfectant. She saw the standing water in the sink and said that the sink must have stopped draining properly over the weekend, as she had not noticed it to be that way the previous week. On 09/17/2026 at 02:47 PM, Maintenance Staff U stated he was notified of equipment not working or repairs that needed to be done via the TELS system. Maintenance U stated all staff members knew how to put in a work order. He said if he gets a work ticket that cannot be completed immediately, he puts it on his board until it is completed. He reported he had not received work orders for the (above-mentioned) concerns and said he would begin the necessary repairs immediately. On 09/17/2026 at 03:04 PM, Administrative Staff A confirmed the facility used TELS to request and monitor repairs or maintenance needs and stated he expected staff to report in TELS if maintenance was necessary. The facility's "Homelike Environment" policy dated 02/2021 documented that residents were provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provide person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment and comfortable and safe temperatures (71°F - 81°F). The facility staff and management minimize, to the extent possible, the characteristics of the facility that reflect a			F0584			

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F0584 SS = E	Continued from page 12 depersonalized, institutional setting.	F0584					
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a medication error rate below five percent. Twenty-six medication administrations were observed with nine errors identified, resulting in a medication error rate of 34.62 %. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 81 revealed the following orders: Carvedilol (a medication used to treat high blood pressure) 25 milligrams (mg), give one tablet by mouth two times a day. Provera (medroxyprogesterone acetate-a medication used to treat hormonal conditions) 20 mg, give one tablet by mouth once daily. Metformin hydrochloride (a medication used to treat high blood sugar) 500 mg, give one tablet by mouth two times a day. Miralax Oral Powder (polyethylene glycol 3350 - a medication used to treat constipation), 17 grams (gm). Give one scoop by mouth one time a day, in the morning. R81's EHR lacked an order for Ensure (nutritional supplement) for R81. R81's EHR lacked orders for medications to be crushed and/or mixed and lacked an order for Ensure (a liquid supplement to provide nutrition) 237 milliliters (mL) that crushed medications were mixed into and given to R81. Observed on 09/16/2026 at 07:58 AM, Licensed Nurse (LN) NN crushed R81's Carvedilol, Provera,	F0759					

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F0759 SS = E	Continued from page 13 and Metformin medications and placed them into a plastic cup. Observed on 09/16/2026 at 08:16 AM, LN NN dropped the Miralax Oral Powder cap onto the floor. LN NN picked the cap up from the floor and poured the Miralax into the cap, then mixed the medication into R81's cup and mixed it with the Ensure and the crushed medications. Observed on 09/16/2026 at 08:21 AM, Administrative Nurse D directed LN NN to dispose of the cup of medications mixed with the Ensure and the Miralax. Administrative Nurse D also directed LN NN to dispose of the Miralax cap that was dropped onto the floor. Observed on 09/16/2026 at 08:22 AM, LN NN crushed R81's oral tablet medications, mixed them all in a cup with Miralax (from a new bottle and a new cap) and the Ensure. Observed on 09/16/2026 at 08:35 AM, LN NN provided R81 with her crushed and mixed medications in a plastic cup with a straw. On 09/16/2026 at 08:17 AM, LN NN reported that if a medication lid used for measuring the medication was dropped onto the floor, it could happen that it would still be used for the administration of the medication. On 09/16/2026 at 08:21 AM, Administrative Nurse D reported that if a medication was mixed or crushed, a physician's order was required. She also stated that if a medication or the cap to any medication, especially if it was used to measure the medication, fell onto the floor or was exposed to any contaminant, the cap or medication was not to be used and was to be disposed of. On 09/16/2026 at 08:49 AM, LN NN reported that all oral medication tablets were crushed and mixed with Miralax and Ensure. She also reported that there was no current order to crush R81's medications or to combine them, and reported there was no order for the Ensure and no current order to crush and combine the medications. On 09/16/2026 at 08:49 AM, LN NN reported that if there is not an order to crush medications, she would observe a resident's ability to swallow and then determine if their medications should be crushed before administering them. On 09/16/2026 at 09:24 AM, LN H reported that a	F0759					

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F0759 SS = E	Continued from page 14 medication should never be given without an order, and any medications that are crushed or mixed must have an order from a physician stating that. LN H also reported that if a medication, or anything that a medication is measured with, is dropped onto the floor, the medication or the thing that measured the medication should not be administered or used and should be discarded. The facility's policy "Medication and Treatment Orders," dated July 2016, documented that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.	F0759					
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F0880					

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F0880 SS = E	Continued from page 15 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 adequate infection control practices related to urinary catheter (tube inserted into the bladder to drain urine) care 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) personal protective equipment (PPE), cleaning of the Sit to Stand (mechanical device used to transfer individuals between surfaces) lift and proper handwashing during resident care and serving meal	F0880					

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F0880 SS = E	Continued from page 16 trays. Findings included: - On 09/15/2026 at 07:25 AM, Resident (R) 32 sat in her wheelchair in the hallway outside of her room. She had an oxygen tank on the back of the wheelchair with oxygen tubing wrapped around it and the nasal cannula laid on the floor. On 09/15/2026 at 08:21 AM, the clean linen room near the second-floor nurse's station was unlocked, and there were four clean washcloths on the floor in front of the clean linen cart. On 09/15/2026 at 01:12 PM, the locked residential unit sink had food debris on it, and the counter had cut-out linoleum with exposed glue areas. The dining area in the locked unit had a hole in one of the lower walls that was approximately 12-15 inches long, with drywall exposed. On 09/15/2026 at 01:18 PM, Certified Nurse Aide PP (CNA) handed out meal trays to the residents and placed dirty trays on the meal cart and then continued to pass clean trays to residents. CNA PP did not perform hand hygiene between handing out fresh meal trays and picking up dirty meal trays. On 09/16/2026 at 07:59 AM, CNA QQ and CNA RR used the sit-to-stand lift and transferred R102 from his wheelchair to the toilet. The CNAs changed R102's incontinence brief and performed peri-care with gloves and proper hand hygiene. When cares were completed for R102, CNA QQ returned the sit-to-stand lift to the hallway and parked it next to the full-body mechanical lift and did not sanitize it. On 09/16/2026 at 09:12 AM, CNA TT performed incontinent care on R110. CNA TT did not wear a gown, and R10 had an indwelling urinary catheter; she did not change her gloves from the soiled to the clean before she applied ointment to R10's right groin area. CNA TT removed her gloves and did not wash her hands before she reapplied new gloves and proceeded to empty the catheter bag, and she did not use an alcohol wipe on the collection bag port. On 09/17/2026 at 08:45 AM, LNK entered R4's room and changed gloves without washing hands and did not put on the proper PPE before R4's intravenous (IV-administered directly into the bloodstream via a vein) access device was started. LN K then flushed the IV site with Normal saline and attached the IV			F0880			

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F0880 SS = E	Continued from page 17 medication. On 09/16/2026 at 08:12 AM, CNA RR stated that the lifts were to be cleaned by the person who operated them with purple wipes. The purple wipes were kept in the treatment carts in the nurse's area, and the CNAs had to ask the nurses or medication aide to get them for them. CNA RR said that the person who operated the lift was responsible for cleaning it. On 09/16/2026 at 08:20 AM, CNA QQ stated that the staff was supposed to clean the mechanical lift and sit-to-stand lift after they used it, but she had forgotten to do so. On 09/16/2026 at 08:28 AM, Licensed Nurse (LN) I stated that after each use, the mechanical lift and sit-to-stand lifts were to be cleaned and placed in the hallway. The wipes to clean them were stored at the nurse's station for resident safety. On 09/17/2026 at 08:55 AM, LN K stated that she did not wear the gown PPE when she performed the IV start on R4 because the IV system was a needle and there were no body fluids and there was no back flash, so she did not wear a gown. On 09/17/2026 at 10:55 AM, Administrative Nurse D said that the use of EBP PPE was expected when required, and it was expected that all staff performed proper hand hygiene. The facility policy on "Infection Prevention and Control Program," dated 2023, documented that the infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection. The facility policy on "Enhanced Barrier Precautions," dated December 2024, documented that enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug-resistant organisms to the residents. EBP employs barrier gowns and gloves in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply.			F0880			
F0924 SS = E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side.			F0924			

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F0924 SS = E	Continued from page 18 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to provide safe and functional handrails in one of multiple resident hallways. Findings included: - On 09/16/2026 at 01:20 PM, the first left handrail on the first floor of Heritage Hall, north 100 hallway, had missing paint, which exposed wood, and was separating from the wall. The far end, left-hand handrailing of the same hall had missing paint, with exposed wood, and was loose. On 09/17/2026 at 10:35 AM, Certified Nurse Aide (CNA) RR stated that all staff were responsible for notifying the maintenance personnel of any broken equipment or building maintenance issues. She said that all staff had access to the TELS (building management system for long-term care facilities) system and would put maintenance requests in with that. On 09/17/2026 at 10:42 AM, Licensed Nurse (LN) G said that all staff were responsible for notifying the maintenance staff of any maintenance issues and that this was done with TELS, and all staff had access. On 09/17/2026 at 02:47 PM, Housekeeping/Maintenance U stated that he was notified of maintenance concerns through the TELS system and that all facility staff had access and the ability to put a work order in. He said that it had been approximately three months since he had last checked the handrails and that he was unaware of the handrails on the Heritage halls that were in disrepair. He further stated that he did not have a system in place to regularly monitor and check the handrails. On 09/17/2026 at 03:04 PM, Administrative Staff A said that all staff had the ability to put maintenance work orders in through the TELS system. He said that he expected staff to notify maintenance of any repair issue as soon as it was identified, and he expected the handrails to have been checked at least quarterly for safety reasons. The facility policy "Homelike Environment," revised February 2021, documented that residents are provided with a safe, clean, comfortable, and homelike environment.			F0924			

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F0941 SS = E	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure agency staff received the required communication training which placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 09/16/2026 at 10:40 AM, a review of the training provided by the facility for agency Certified Nurse Aide (CNA) M and CNA N revealed the following: The facility was unable to provide documentation that CNA M had completed the required communication training. The facility was unable to provide documentation that CNA N had completed the required communication training. On 09/16/2026 at 02:25 PM, Administrative Nurse D verified the two agency CNAs (listed above) did not have the required education. She stated the agency provider was unable to provide the facility with evidence that the CNAs had completed the required education. She stated it would be the staffing coordinator's responsibility to ensure the required education was completed. The facility's "Nurse Aide In-Service Training" policy dated 08/2022 documented that all nurse aide personnel would participate in regular in-service education. Required training topics for all staff (including nurse aides) include communication, resident rights and facility responsibilities, abuse, neglect, and exploitation of residents, quality assurance and performance improvement (QAPI), infection control, compliance and ethics, and behavioral health.	F0941					
F0942 SS = E	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility	F0942					

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F0942 SS = E	Continued from page 20 responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training as required. Findings included: - On 09/16/2026 at 10:40 AM, a review of the training provided by the facility for agency Certified Nurse Aide (CNA) M revealed the following: The facility was unable to provide documentation that CNA M had completed the required resident rights training. On 09/16/2026 at 02:25 PM, Administrative Nurse D verified the one agency CNA (listed above) did not have the required education. She stated the agency provider was unable to provide the facility with evidence that the CNAs had completed the required education. She stated it would be the staffing coordinator's responsibility to ensure the required education was completed. The facility's "Nurse Aide In-Service Training" policy dated 08/2022 documented that all nurse aide personnel would participate in regular in-service education. Required training topics for all staff (including nurse aides) included communication, resident rights and facility responsibilities, abuse, neglect, and exploitation of residents, quality assurance and performance improvement (QAPI), infection control, compliance and ethics, and behavioral health.	F0942					
F0943 SS = E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect,	F0943					

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F0943 SS = E	Continued from page 21 exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure agency staff received the required abuse, neglect, and exploitation training. Findings included: - On 09/16/2026 at 10:40 AM, a review of the training provided by the facility for agency Certified Nurse Aide (CNA) M revealed the following: The facility was unable to provide documentation that CNA M had completed the abuse, neglect, and exploitation training. On 09/16/2026 at 02:25 PM, Administrative Nurse D verified that the one agency CNA (listed above) did not have the required education. She stated the agency provider was unable to provide the facility with evidence that the CNAs had completed the required education. She stated it would be the staffing coordinator's responsibility to ensure the required education was completed. The facility's "Nurse Aide In-Service Training" policy dated 08/2022 documented that all nurse aide personnel would participate in regular in-service education. Required training topics for all staff (including nurse aides) included communication, resident rights and facility responsibilities, abuse, neglect, and exploitation of residents, quality assurance and performance improvement (QAPI), infection control, compliance and ethics, and behavioral health.	F0943					
F0945 SS = E	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training	F0945					

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F0945 SS = E	Continued from page 22 that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure agency staff received the required infection control training as required. Findings included: - On 09/16/2026 at 10:40 AM a review of the training provided by the facility for agency Certified Nurse Aide (CNA) M and CNA N revealed the following: The facility was unable to provide documentation that CNA M had completed the required infection control training. The facility was unable to provide documentation that CNA N had completed the required infection control training. On 09/16/2026 at 02:25 PM, Administrative Nurse D verified the two agency CNAs (listed above) did not have the required education. She stated the agency provider was unable to provide the facility with evidence that the CNAs had completed the required education. She stated it would be the staffing coordinator's responsibility to ensure the required education was completed. The facility's "Nurse Aide In-Service Training" policy dated 08/2022 documented that all nurse aide personnel would participate in regular in-service education. Required training topics for all staff (including nurse aides) included communication, resident rights and facility responsibilities, abuse, neglect, and exploitation of residents, quality assurance and performance improvement (QAPI), infection control, compliance and ethics, and behavioral health.			F0945			
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution			F0676			

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F0676 SS = D	Continued from page 23 was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to provide and have readily available method of communication for facility staff and Resident (R) 111, whose primary language was not English. Findings Included: R111's Electronic Medical Record (EMR) documented diagnoses of anxiety and dysphagia (swallowing difficulty). R111's "Quarterly Minimum Data Set" (MDS), dated			F0676			

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F0676 SS = D	Continued from page 24 07/07/2026, documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R111 needed set-up or clean-up assistance with eating, needed a mechanically altered diet, and was dependent on staff for activities of daily living (ADLs). R111's "Care Plan," dated 03/19/2026, documented cognitive impairment and instructed staff to explain all care to R111 before providing the care to reduce tension and provide a comfortable experience. R111's "Care Plan," revised 05/25/2026, documented that she was resistive to cares, medication administration, nursing assessments, repositioning, incontinent brief checks, and showers. Staff were instructed to give R111 a clear explanation of all care activities prior to, and as they occurred during each contact. Staff were also instructed to provide R111 opportunities for her choice during care provision. On 09/16/2026 at 09:41 AM, R111 laid in her bed and watched television with the language in English. On 09/16/2026 at 09:41 AM, R111 laid in her bed while staff were present and she spoke Spanish to them. On 09/17/2026 at 09:00 AM, it was observed that R111 had no access to, and was unable to access, the language barrier services to communicate effectively with facility staff. On 09/16/2026 at 10:33 AM, Social Services Y stated that the staff communicated with R111 by locating a staff member who spoke Spanish in the building, or they would call R111's daughter to translate for her. She stated that there was a translation line that the staff could also use. On 09/17/2026 at 08:00 AM, Certified Nurse Aide (CNA) WW stated that she was given a cardex when she received shift report that indicated to her that R111 was Spanish speaking. On 09/17/2026 at 08:46 AM, Licensed Nurse (LN) MM provided medications to R111. She stated that she tapped her chest to indicate to R111 that she was giving her the heart medication, as she did not speak Spanish. LN MM stated that she would look at R111 for facial grimacing to indicate if she was in pain, but she did not appear to be at that time. She would have to ask the director of nursing for the number to the language assist line, as there was not			F0676			

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F0676 SS = D	Continued from page 25 one for that unit in the nurse's area or posted in R111's room. On 09/17/2026 at 08:58 AM, Maintenance W stated that he spoke Spanish and had been at that facility for two years, so he knew that she was Spanish-speaking; otherwise, he would not have known. On 09/17/2026 at 09:09 AM, CNA VV stated that she would receive the information that R111 had a language barrier in report and she would use the Google Translator on her phone to communicate with R111. The facility's "Translation and/or interpretation of Facility Services" policy dated November 2020 documented that the facility's access language would ensure that individuals with limited English proficiency should have meaningful access and services provided by the facility.	F0676					
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 a safe environment when Resident's (R) 12 was pushed in his wheelchair with his feet dangling between the foot pedals. Findings included: - R12's Electronic Medical Record (EMR) documented diagnoses of cerebral vascular accident (stroke), and Parkinson's disease. R12's "Quarterly Minimum Data Set" (MDS), dated 07/24/2026, documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented that R12 had	F0689					

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F0689 SS = D	Continued from page 26 impairment to both sides' upper and lower extremities and used a wheelchair for mobility. R12 required set-up to clean-up assistance for eating and oral hygiene, and partial to moderate assistance for upper body dressing. R12 was dependent on staff for all other activities of daily living (ADLs) and transfers. On 09/16/2026 at 01:25 PM, R12 sat in his wheelchair on the first floor just in front of the elevator. R12 appeared relaxed, and his feet were resting on the ground between the foot pedals of his wheelchair. A staff member was getting onto the elevator and grabbed R12's handles on the back of the wheelchair, pushed him toward the concierge station, and did not maintain a hold of R12's wheelchair. R12 freewheeled for approximately eight feet while his feet slid on the ground between the foot pedals of his wheelchair. On 09/17/2026 at 10:355 AM, Certified Nurse Aide (CNA) RR stated that foot pedals were required anytime a resident was pushed in their wheelchair and that their feet were to be on the foot pedals. On 09/17/2026 at 10:42 AM, Licensed Nurse (LN) G stated that foot pedals were required for any chair, wheelchair, or shower chair when a resident was pushed in it through the halls. On 09/17/2026 at 10:49 AM, Administrative Nurse D stated that foot pedals were always required anytime a resident was pushed in a wheelchair, and their feet were not to be dangling. The facility policy "Safety and Supervision of Residents," revised July 2017, documented that the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.	F0689			
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.	F0732			

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F0732 SS = C	Continued from page 27 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure the posted daily nurse staffing data contained the required information.	F0732					

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F0732 SS = C	Continued from page 28 Findings included: - On 09/16/2026 at 10:01 AM, the daily posted staffing sheets from 03/01/2025 to 09/15/2026 were reviewed. The daily posted staffing sheets from 08/15/2026 to 08/31/2026 lacked the actual hours worked and the total hours worked for the direct care staff. On 09/16/2026 at 11:10 AM, Administrative Staff A stated that the facility would return to the use of the previous form that contained the total hours worked. The facility's "Posting Direct Care Staffing Numbers" policy, dated 08/2022, documented that the facility will post, on a daily basis for each shift, nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.			F0732			
F0814 SS = C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly by failing to ensure the lid of the dumpster was kept closed and failing to adequately contain garbage and refuse. Findings included: - During an initial tour of the garbage area on 09/16/2026 at 07:10 AM the following concerns were identified: 1. Three of the four dumpsters were overfilled, with covers unable to be closed. Random trash littered the ground, including kitchen trash and construction-type trash. 2. On 09/16/2026 at 3:15 PM, two of the dumpsters had been emptied, with the cover open on one dumpster. Random trash still littered the area around all four dumpsters, including construction-type trash. 3. On 09/17/2026 at 07:35 AM, two dumpsters were observed with the covers open; one of which was overflowing and one not full. Food was observed			F0814			

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F0814 SS = C	Continued from page 29 dumped directly onto grass, with trash littering the area around all four dumpsters, and construction-type trash remained. During an interview on 09/17/2026 at 07:56 AM, Dietary Staff (DS) BB stated that, with the use of the Styrofoam serving dishes, they have had more trash. She stated the dumpsters included three for trash and one for cardboard to be recycled. DS BB stated that the lids should be closed and there should be no trash on the ground; if any trash fell on the ground, it should be picked up. She stated there should be no food on the ground, and it was the facility's responsibility to ensure the area is cleaned up. During an interview on 09/17/2026 at 08:09 AM, Administrative Staff A stated he expected the lids to be shut on the dumpsters with no trash or food on the ground. Administrative Staff A stated the facility had increased the garbage pickup since they have been using the Styrofoam for serving meals. He stated the maintenance staff was dealing with the garbage company. The facility policy for "Sanitization", dated November 2022, included: Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered).			F0814			