STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175562	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCH HOUSE SENIOR LIVING LLC	**2900 CAMPUS DRIVE , GARDEN CITY, Kansas, 67846**

(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 Licensure Resurvey and Complaint Investigation regarding allegations in 3187222. The census was 45. The sample included eight residents.	F0000		
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 communicable disease or infections should be	F0880		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0880 SS = E	Continued from page 1 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation and record review, the facility failed to follow appropriate infection control practices related to sanitization of shared equipment, and sanitary storage of respiratory equipment. Additionally, the facility failed to properly transport personal linens. Findings included: 1. On 09/30/2026 at 08:29 AM, Resident (R) 37's oxygen tubing hung off the oxygen tank on the back of her wheelchair, and the nasal cannula lay on top of the back of the wheelchair.	F0880		

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F0880 SS = E	Continued from page 2 2. On 09/30/2026 at 08:35 AM, R5's nebulizer tubing and mask lay directly on the bedside table; the nebulizer was intact with an empty atomizer chamber. 3. On 09/30/2026 at 08:38 AM, R34's oxygen tubing hung off the tank on the back of the wheelchair, and the nasal cannula lay on the seat. 4. On 09/30/2026 at 11:00 AM, R2's oxygen cannula connected to the oxygen concentrator lay directly on her recliner. On 09/30/2026 at 02:40 PM, Certified Nurse Aide (CNA) M reported that any oxygen tubing not in use was to be stored in a bag. CNA M reported that the nurse took care of the nebulizer equipment. On 09/30/2026 at 02:47 PM, Licensed Nurse (LN) G reported that oxygen tubing that was not in use was to be stored in a bag. LN G reported that the nebulizer equipment was to be rinsed out and air-dried after use and stored in a bag. On 09/30/2026 at 04:01 PM, Administrative Nurse D reported that she expected the oxygen cannulas to be placed in a bag when not in use. She reported that she expected the nebulizer equipment to be stored in a bag when not in use. 5. On 09/30/2026 at 01:50 PM, Laundry Staff V and Laundry Staff W pushed a yellow covered linen cart down the 100 hallways that had a big hole on the top that was approximately 12 inches. The cart contained personal linen. Laundry Staff V and Laundry Staff W entered three of the residents' rooms in the 100 hallways, and no hand hygiene was performed between the resident rooms as they opened closets and drawers. On 09/30/2026 at 0159 PM, Laundry Staff V and Laundry Staff W reported that the linen cart hole had been like that for a while and was not sure if Maintenance Supervisor U knew about the hole. Laundry Staff W reported that she did not use the hand sanitizer when she passed the linen and was not sure if she was required to use it in residents' rooms. On 09/30/2026 at 04:01 PM, Administrative Nurse D reported that she expected the laundry personnel to sanitize their hands between the resident rooms when passing any linen. Administrative Nurse D reported that she expected the linen cart covers to have no holes or rips, and she would discuss it with	F0880		

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F0880 SS = E	Continued from page 3 Maintenance Supervisor U. 6. On 09/30/2026 at 02:12 PM, CNA N pushed the mechanical lift out of R8's room after she assisted R8 to the toilet and into her bed with CNA O; she placed the mechanical lift into an alcove. No sanitizing was performed on the lift. On 09/30/2026 at 02:30 PM, CNA N reported that she did not sanitize the mechanical lift because she could not locate the sanitizing wipes. On 09/30/2026 at 04:01 PM, Administrative Nurse D reported that she expected the staff to sanitize the shared resident equipment between residents. The facility's policy "Oxygen Safety and Management," dated 03/22/2019, documented that oxygen cannulas and masks should not be allowed to encounter the floor or other potentially dirty surfaces. If this occurs, they should be replaced. The cannulas or masks should be stored in plastic bags to prevent contamination. The facility's policy "Linen Transportation" dated 11/28/2017, documented that linens should be transported in a manner that prevents contamination. Clean linens should be covered when transported through common areas. The facility's policy "Standard Precautions," dated 11/28/2017, documented that reusable equipment is not used for the care of another resident until it has been appropriately cleaned.	F0880		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to capture a significant change on	F0637		

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F0637 SS = D	Continued from page 4 Resident (R) 32 when the resident had multiple areas of decline in activities of daily living and increased behaviors. Findings included: - The Electronic Health Records (EHR) documented that Resident (R)32 had diagnoses of Alzheimer's disease, dementia, major depressive disorder, and anxiety. The 05/08/2026 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of six, which indicated severely impaired cognition. R32 had other behaviors not directed towards others that occurred one to three days during the assessment look-back period. R32 required partial/moderate assistance with bathing but was otherwise independent with cares and transfers. The 05/08/2026 " Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R32 was a long-term resident of the facility with severely impaired cognition. R32 was independent with most cares but required reminders of what she needed to do. R32's 07/31/2026 "Quarterly MDS" documented a BIMS score of 99, which indicated the assessment could not be completed. The MDS documented R32 had memory problems with severely impaired cognition. R32 had behaviors that included delusions and other behaviors not directed towards others, which occurred four to six days during the assessment look-back period. R32 was dependent on staff for personal hygiene, toileting hygiene, lower body dressing, and application of footwear. R32 required partial to moderate assistance for upper body dressing, supervision or touching assistance for bathing, cleanup and setup assistance for oral hygiene, and eating was performed independently. R32 required partial to moderate staff assistance for sitting-to-lying and toilet transfers, partial to moderate assistance for chair transfers, and supervision and touching assistance for tub and shower transfers. On 09/30/2026 at 08:10 AM, R32 rested in her bed with blankets covering her body On 09/30/2026 at 05:33 PM, Certified Medication Aide (CMA) R reported that R32 had declined in her ADLs at an unspecified time in 05/2026 or 06/2026; R32 was independent and then declined to being totally dependent on the staff.	F0637		

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F0637 SS = D	Continued from page 5 On 09/30/2026 at 05:40 PM, Licensed Nurse (LN) H reported that R32 had a decline before a recent hospitalization. R32 became more dependent on the staff for her care and remained that way when she was readmitted. LN H reported that she did not know if R32 had any therapy for her decline in her abilities to care for herself. On 09/30/2026 at 05:48 PM, Administrative Nurse E confirmed the above findings on the 05/08/2026 and 07/31/2026 MDS assessments. Administrative Nurse E stated that a significant change MDS should have occurred but was unable to explain why one was not performed. Administrative Nurse E stated that the corporate staff usually initiated a significant change MDS when necessary. The facility did not provide a policy related to significant change MDS assessments.	F0637		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F0655		

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F0655 SS = D	Continued from page 6 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, and record review, the facility failed to develop a person-centered baseline care plan for Resident (R) 5 within the required time frame that included instructions for staff to use a nebulizer (a device which changes liquid medication into a mist easily inhaled into the lungs) to deliver nebulized medications. Findings included: - R5's Electronic Health Record (EHR) documented diagnoses that included asthma (a disorder of narrowed airways that causes wheezing and shortness of breath). R5's 09/16/2026 "Admission Minimum Data Set" (MDS) documented that R5 was admitted to the facility on 09/10/26. The assessment documented a "Brief Interview for Mental Status" (BIMS) score of 13, which indicated intact cognition. R5 did not receive any special treatments or therapies. R5's "Baseline Care Plan", dated 09/10/2026,	F0655		

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F0655 SS = D	Continued from page 7 lacked instructions for nebulized medication use. R5's "Physician Orders" documented an order, Albuterol Sulfate (a medication used to open lung passages) Nebulization Solution, 1 vial, inhale orally via nebulizer every four hours as needed for wheezing pre breathing treatment, dated 09/10/2026, cancelled 09/28/2026. R5's "Physician Orders" documented an order, Albuterol Sulfate Nebulization Solution, 1 vial, inhale orally via nebulizer every four hours as needed for wheezing post breathing treatment, dated 09/10/2026, cancelled 09/28/2026. On 09/30/2026 at 08:35 AM, R5 rested in bed, with a nebulizer machine with an intact nebulizer setup and an empty atomizer chamber sat on top of her bedside cabinet. On 09/30/2026, Administrative Nurse D and Administrative Nurse E stated that if a resident used a nebulizer and was admitted to the facility with physician orders for nebulized medication, the instructions for nebulizer use should be included in both the baseline and comprehensive care plans. The facility's "Care Plan" policy, dated 03/21/2024, documented that the charge nurse was responsible for creating the initial baseline care plan within 48 hours after admission and that it must be individualized to address resident-specific needs.	F0655		
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	F0656		

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F0656 SS = D	Continued from page 8 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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 and implement a person-centered comprehensive care plan for Resident (R) 2 related to the use of supplemental oxygen. Findings included: - R2's Electronic Health Records (EHR) documented diagnoses of Alzheimer's disease, anxiety, and chronic respiratory failure (where the lungs cannot pass enough oxygen into the blood) with hypoxia (inadequate supply of oxygen). R2's 05/01/2026 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of zero, which indicated severely impaired cognition. The assessment documented R2 was dependent on staff for all cares except eating, which required partial to moderate staff assistance, and R2 received oxygen R2's 07/24/2026 "Quarterly MDS" documented a BIMS score of 99, which indicated the	F0656		

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F0656 SS = D	Continued from page 9 assessment could not be completed. The MDS documented that R2 had memory problems with severely impaired cognition. It documented that R2 was dependent on staff for all care and utilized supplemental oxygen. R2's "Physician Orders" documented an order for 2 liters (L) of oxygen continuously at bedtime. Staff were to change the oxygen tubing every Sunday and to monitor, every shift, R2's pulse oxygen (SpO2) levels and notify the physician if the level was below 90%, and as needed for low SpO2, dated 07/13/2026. On 09/30/2026 at 11:13 AM, R2 rested in a recliner in the common area; an oxygen cannula was observed in place, connected to an oxygen tank hanging on R2's wheelchair. R2's 07/14/2023 "Care Plan", reviewed 09/30/2026, did not document instructions to staff for the use of oxygen equipment. On 09/30/2026 at 06:33 PM, Administrative Nurse E and Administrative Nurse D stated that oxygen use should be addressed and documented on a resident's person-centered comprehensive care plan. The facility's "Care Plan" policy, dated 03/21/2024, documented that a care plan would be developed for each resident that included measurable objectives to meet a resident's medical, nursing, mental, and psychological needs. The comprehensive care plan should reflect individualized problems, goals, and interventions.	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: Based on observation, interview, and record review, the facility failed to ensure Resident (R) 8 remained free from accident hazards when staff failed to place her floor mat next to her bed as instructed by her plan of care. Findings included: - R8's Electronic Medical Record (EMR) revealed	F0689		

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F0689 SS = D	Continued from page 10 diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity, and weakness). R8's 01/13/2026 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R8's MDS documented that she required moderate assistance with transfers and had no fall history. R8's 01/19/2026 "Falls Care Area Assessment" (CAA) documented R8 was a new admission, transferred from another nursing home. R8 was not ambulatory at the time, and she was dependent on a wheelchair for locomotion and partial assistance with transfers. R8's "Care Plan," dated 04/16/2026, instructed staff to ensure that a fall mat was placed next to R8's bed at all times when she was in bed. R8's "Fall Assessment," dated 01/06/2026, documented R8 was a potential fall risk. R8's "Fall Assessment," dated 03/30/2026, documented R8 was a high fall risk and required assistance with transfers and mobility. R8's "Fall Assessment," dated 06/22/2026, documented R8 was a high fall risk due to the diagnoses of Parkinson's disease, history of falls, and presence of cardiac medications and narcotic medications. R8's "eINTERACT Summary for Providers Situation" dated 02/25/2026 at 05:07 AM documented the change in condition/s reported on this evaluation as falls. The functional status evaluation was a fall. R8's "eINTERACT Summary for Providers Situation," dated 04/15/2026 at 11:45 PM, documented that the change in conditions reported on this evaluation was falls. At the time of the evaluation, the resident's relevant medical history included dementia, and R8 was confused and consistently called for assistance to use the bathroom. R8's bed was in the lowest position, and she may benefit from a fall mat. R8's "Progress Notes" lacked any documentation about her having falls. The facility's "Unwitnessed Fall Report," dated 02/24/2026 at 08:14 PM, documented that R8 was found seated on the floor in the television room with	F0689		

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F0689 SS = D	Continued from page 11 her back facing the dining room and feet facing the south windows, with the wheelchair off to the right in back of her. R8 was wearing non-skid socks. R8 stated, "I just wanted to sit down." The facility's "Unwitnessed Fall Report Notes," dated 02/26/2026, documented that the nursing staff assisted R8 to the chair in the TV room and encouraged her to call for help and wait for assistance when she was ready to transfer back to her wheelchair. The facility's "Unwitnessed Fall Report," dated 04/15/2026 at 11:45 PM, documented that R8 was on the floor in her room in front of her bed. R8 reported she was going to get socks. The facility's "Unwitnessed Fall Report Notes," dated 04/16/2026, documented that R8 had no injuries, and the nursing staff assisted R8 to the bathroom and then to bed. The note lacked any documentation that fall interventions were implemented post-fall. On 09/30/2026 at 02:02 PM, Certified Nurse Aide (CNA) O and CNA N assisted R8 to her room in her wheelchair and used the sit-to-stand lift to transfer R8 onto the toilet; then CNA O and CNA N assisted R8 into bed. CNA O and CNA N lowered R8's bed, covered her up, and gave her the call light. No fall mat was placed on the floor next to her bed, and no fall mat was observed in R8's room. On 09/30/2026 at 02:24 PM, CNA O reported that the fall interventions would be on the care plan and CNA Kardex, and she reported she was not sure if any of the CNAs had access to that in EMR. On 09/30/2026 at 02:28 PM, Licensed Nurse (LN) H reported that R8 did not have a fall mat on the CNA worksheet that documented all the fall information and reported that the form had not been updated since 08/24/2026. On 09/30/2026 at 02:30 PM, CNA N logged onto R8's EMR and reported she had no access to a Kardex and only had access to the first page of the care plan. On 09/30/2026 at 02:33 PM, CNA N and CNA O reviewed R8's care plan on the EMR that LN H provided and read that R8 should have a fall mat, and they both reported they have never seen a fall mat in R8's room. On 09/30/2026 at 02:47 PM, LN G reported that she	F0689		

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F0689 SS = D	Continued from page 12 had never seen a fall mat in R8's room. LN G reported that Administrative Nurse E would update the care plan after falls. On 09/30/2026 at 03:37 PM, Administrative Nurse E reported that Administrative Nurse D or herself would update the fall intervention on the care plan and reported that she did not update the care plan for a fall mat for R8. Administrative Nurse E reported that for the fall on 02/24/2026, the intervention was to remind the resident to call for assistance and thought that was documented on R8's care plan. Administrative Nurse E reviewed R8's care plan and verified R8 did have a fall mat documented by Administrative Nurse E on 04/16/2026 and then reported that the nurse had documented that on the "eINTERACT" note as a recommendation. Administrative Nurse E reported that she thought R8 had a fall mat at one time in her room. She reported that she did not put the fall interventions on the CNA worksheet as it would take up too much room on the form. On 09/30/2026 at 03:49 PM, Administrative Nurse D reported that she expected all fall interventions to be documented on the residents' care plans and implemented. The facility's policy "Falls," dated 04/27/2018, documented that individualized care plan interventions would be developed for residents identified through assessment as being at fall risk. Those interventions will be reviewed and updated on a regular basis and if/when a fall occurs.	F0689		
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to provide appropriate supervision for Resident (R) 42 related to inappropriate physical contact with another resident, R32. Findings included: - R42 's Electronic Health Record (EHR) documented diagnoses of diabetes mellitus type 2,	F0744		

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F0744 SS = D	Continued from page 13 chronic kidney disease, anxiety, and alcoholic cirrhosis (chronic degenerative disease of the liver) without ascites (abdominal swelling caused by accumulation of fluid, most often related to liver disease). R42's 06/25/2026 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The assessment documented that R42 had no behaviors during the look-back period and he utilized a motorized wheelchair for independent locomotion. R42's 06/25/2026 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented that R42 was recently admitted to the facility from assisted living due to his requirement of more assistance with his activities of daily living (ADLs) care. R42's 09/11/2026 "Quarterly MDS" documented a BIMS score of seven, which indicated severely impaired cognition. The assessment documented no behaviors during the look-back period and utilized a motorized wheelchair for independent locomotion. R42's "Care Plan", reviewed 09/30/2026, documented a focus of cognitive loss, initiated on 06/22/2026, contained an intervention which documented that R42 became concerned when others seemed upset, and staff were instructed to remind R42 not to touch others to attempt to comfort them because it could make them feel uncomfortable, dated 09/04/2026. R42's EHR "Progress Note" tab documented the following notes:On 08/01/2026 at 02:52 PM, "Behavior Note," Licensed Nurse (LN) I documented an unnamed Certified Medication Aide (CMA) reported that while in the dining area, R42 approached another resident, R32 who was crying. R42 touched R32's hand and inner thigh. The CMA staff immediately intervened and removed R32 from the situation to prevent further contact and notified the nurse, and the nurse then notified Administrative Nurse D.On 09/03/2026 at 11:30 AM, "General Note," Administrative Staff A documented that R42's representative was notified of an incident involving R42's behavior towards another resident.On 09/03/2026 at 03:30 PM, "General Note," LN I documented that at approximately 10:55 AM, LN I observed R42 near another resident who appeared to be in distress. LN I documented that R42 was observed rubbing the resident's right inner thigh. LN I instructed R42 to stop touching the other resident and explained that the behavior was inappropriate, and R42 wheeled himself away from the other resident. LN I documented that she reported the incident to Administrative Nurse D, Administrative Nurse E, Social Services X, and R42's physician. R42's EHR "Tasks" tab documented the only behavior monitoring staff performed was related to	F0744		

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F0744 SS = D	Continued from page 14 anxiety. On 09/30/2026 at 09:00 AM, R42 rested in his room with his eyes closed On 09/30/2026 at 12:20 PM, Administrative Staff A reported that the incident that occurred on 09/03/2026 was the first incident in which R42 displayed any behaviors towards females. Administrative Staff A was unaware of the incident documented in R42's EHR on 08/01/2026. On 09/30/2026 at 12:40 PM, Administrative Nurse D reported to the survey team and Administrative Staff A that she had no recollection of an incident involving R42 and R32 being reported to her on 08/01/2026. On 09/30/2026 at 12:45 PM, Administrative Nurse D and Administrative Nurse E provided an undated, unnotarized "Witness Statement" signed by CMA S that documented that on 08/01/2026 at 02:30 PM, R32 was standing and crying in front of R42 when R42 took R32's hand and caressed her hand and touched her inner left thigh. CMA S documented that R32 and R42 were separated. Administrative Nurse D then stated she recalled getting a phone call from LN I, and the incident was discussed with Administrative Staff A. The incident was investigated internally and determined that R42 had attempted to console R32 and there was no malicious intent from R42. On 09/30/2026, LN I and CMA S were unavailable for interview. The facility's "Dementia" policy, dated 04/27/2018, documented that residents who are diagnosed with or displayed signs of dementia would receive appropriate treatment and services to attain and maintain the highest practicable well-being. The policy did not address the topic of supervision to prevent unwanted or inappropriate physical contact.	F0744		