STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175332	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	**1100 W 15TH STREET , OTTAWA, Kansas, 66067**

(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 investigation 3186515, 3131424, 3124739, and 3031647. The census was 66. The sample included 18 residents.	F0000		
F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F0725		

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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F0725 SS = F	Continued from page 1 duty. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure sufficient nursing staff were available during weekend shifts to provide nursing care and services to meet residents' needs in accordance with their comprehensive assessments and plans of care determined by the facility's resident census and acuity. Findings Included: - An inspection of the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) staffing documentation confirmed excessively low weekend staffing for Fiscal Year (FY) 2026 Quarter (Q) 1 (10/01/2025 to 12/31/2025), FY 2026 Q2 (01/01/2026 to 03/31/2026) FY 2026 Q3 (04/01/2026 to 06/30/2026), and FY 2026 Q4 (07/01/2026 to 09/30/2026). The PBJ report documented the facility's Star Staffing Rating Equals 1 for the FY 2026 Q1 (10/01/2025 to 12/31/2025). The facility displayed a spreadsheet which indicated the number of staff required for the census levels. Review of the staffing hours for the weekends of 12/13/2025 to 12/14/2025, 02/21/2026 to 02/22/2026, 04/25/2026 to 04/26/2026, 06/20/2026 to 06/21/2026, and 08/23/2026 revealed the facility had less staff than the staffing ladder indicated for the facility census at that time. On 10/26/2026 at 03:55 PM, Administrative Staff A reported that she was aware the facility had had lower staffing on the weekends. She provided a staffing ladder document used to determine the staffing ratio. On 10/27/2026 at 09:35 AM, CNA Staff M reported the facility was short staffed sometimes on the weekends when staff called in. On 10/27/2026 at 10:49 AM, Administrative Staff D reported she was not aware of low weekend staffing as she had only been with the facility for two months. She reported she believed cares were being	F0725		

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F0725 SS = F	Continued from page 2 performed even if staffing was low. On 10/27/2026 at 10:54 AM, Administrative Staff A reported that staffing had been a struggle. She verified there had been low staffing. She reported she has had leadership staff come in on weekends, though it was reflected on PBJ due to staff not clocking in since they were salaried employees. She verified information provided to the PBJ was accurate for actual scheduled nursing staff. The facility's "Staffing" policy, revised January 2023, documented the facility will employ and will schedule sufficient personnel to provide care, during all hours, required to each resident to assure residents' health, safety, comfort, and supervision. The number of staff scheduled each shift will be determined by the facility approved staffing ladder and/or based on the acuity of care requirements for the residents currently in the facility and can change based on the fluctuating acuity levels of care.	F0725		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812		

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F0812 SS = F	Continued from page 3 Based on observation and interview, the facility failed to ensure staff stored food items in accordance with the professional standards for food service safety. Findings included: - On 10/25/2026 at 07:30 AM, observation revealed Dietary CC setting up for breakfast. Further observation revealed the following: The floor in the kitchen under the sinks and along the walls all around the kitchen had visible food particles and crumbs spread throughout the kitchen area. The pantry room had a brown sugar packet on the floor with an open empty Ziplock bag next to it on the floor. There was an open cardboard box with graham cracker packets in it and a broken package in the box with a couple of unwrapped graham crackers in the box. An open clear plastic bag of fruit ring cereal lacked a label and opened date. A clear container labeled corn meal with a date of “12/04” on it had no year, and another one labeled flour with a date of “06/18” lacked a year or precise date it. A Ziplock bag of baking powder dated “10/20” lacked a precise date. There was a closet with dirty mops and rags in it without a door. It had a pair of black plastic gloves on the floor; a plastic bag tied shut sitting on the floor; a cleaning bottle with liquid in it laid on its side on the floor, and two green cleaning towels were also on the floor. On a metal shelf, a clear plastic container with onions in it was unlabeled and undated. There was a plastic round trash can lid under the shelf on the floor. Two metal carts with shelves contained large, canned goods with no year dated on them. A different shelf had spices on it that lacked precise dates. An opened bag of Hawaiian rolls half full lacked an opened date. The clean dish shelf by the dishwasher had two bowls, a cup, and a flyswatter on the floor under it.	F0812		

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F0812 SS = F	Continued from page 4 A cart with dish racks sitting on it had visible food debris on the bottom of it. A cart with clear plastic containers of food lacked a precise date. The dining area had a nourishment area with a sink and a coffee machine on the counter that had orange liquid spilled on it, with clean cups on the trays next to the spilled liquid. The sink had visible brown debris on it. The tea machine was stored under the sink. On 10/26/2026 at 11:26 AM, the grill had what appeared to be pancake batter on it from breakfast with the dirty spatula on it, and had not been cleaned. There was an uncovered metal container with yellow liquid butter in it and a red rubber baster still in it. On 10/27/2026 at 09:26 AM, the grill had multiple eggshells broken next to it and the dirty spatula on it with egg residue on the grill. A hashbrown was on the floor next to the grill. On 10/27/2026 at 09:23, Dietary Staff DD stated the stored food should be dated but she did not feel that it needed to have the year on it if the staff were checking for outdated items every day. Dietary Staff DD said the grill should be cleaned after use and before lunch from breakfast. On 10/27/2026 at 09:28 AM, Dietary Staff BB stated that the grill should be scraped after every meal and was to be fully cleaned at night. Dietary Staff BB said the eggshells should have been thrown away, and staff were trained in the kitchen with a skills checkoff sheet upon hire and then yearly. Facility policy “Rock Creek of Ottawa Dietary Services” dated 01/2023, documented that it was the policy of that facility to procure food from sources approved or considered satisfactory by Federal, State, and/or local authorities. The facility will store, prepare, distribute, and serve food under sanitary conditions.	F0812		

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F0583 SS = E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff secured and protected the privacy and confidentiality of resident’s medical records and protected health information (PHI). Findings included: - On 10/25/2026 at 07:15 AM, Licensed Nurse (LN) I left her medication cart unlocked and unattended with seven resident’s personal medical information on the west hall. On top of the cart were weights	F0583		

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F0583 SS = E	Continued from page 6 and vitals with resident names with blood sugar glucometer, lancet, cotton ball, and a narcotic count book. On 10/27/2026 at 09:46 AM, LN G left her medication cart on the west hall unattended with the laptop screen unlocked, and a resident's personal medical information and medications were visible on the screen. On 10/27/26 at 07:15 AM, LN I stated that she knew she had left it unlocked as she had to go to the dining room for something. On 10/27/2026 at 09:50 AM, LN G stated that the nursing medication cart should be locked and the laptop screens locked if the nurse was not at the medication cart and if the nurse is not in the same location that the medication cart is in. LN G stated PHI should never be visible to anyone but the person that is authorized to access or see that information. On 10/27/2026 at 12:46 PM, Administrative Nurse D stated that she expected that if the nurse was not at the medication/treatment cart that it should be locked and any PHI would not be visible to anyone who is not authorized to view that resident information. Facility Policy "Rock Creek of Ottawa Nursing Administration Medical Records" dated 01/2025, documented that the types and amount of information gathered from the resident shall be limited to that information necessary to carry out the function of the person or service requesting the information. All individuals engaged in collection, handling, or dissemination of resident-related information shall be specifically informed of their responsibility to protect the confidentiality of the information.	F0583		
F0638 SS = E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once	F0638		

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F0638 SS = E	Continued from page 7 every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure a “Quarterly Minimum Data Set” (MDS) assessment was completed within 14 days of the Assessment Reference Date (ARD) and also failed to complete and submit the “Quarterly MDS” every 92 days for Resident (R) R30, R48, R63, and R67. Findings included: - 1. R30’s Electronic Medical Record (EMR) MDS tab documented a “Quarterly MDS” dated 06/26/2026. A “Quarterly MDS” had an ARD date of 09/26/2026 but was not completed until 10/21/2026. 2. R48’s MDS tab in the EMR documented an “Annual MDS” with an ARD date of 07/10/2026 and the next “Quarterly MDS” had an ARD date of 09/26/2026 but was not completed until 10/19/2026. 3. R63’s MDS tab in the EMR documented a “Quarterly MDS” with an ARD date of 06/25/2026 and a “Quarterly MDS” with an ARD date of 09/25/2026 that was not completed until 10/22/2026. 4. R67’s MDS tab in the EMR documented an “Annual MDS” with an ARD date of 06/25/2026a and a “Quarterly MDS” with an ARD date of 09/05/2026 that was not completed until 10/21/2026. On 10/27/2026 at 11:43 AM, Administrative Nurse F stated that the facility had a new program for completing the MDS and some of them may have been started on time but were not completed and submitted by the 14-day timeframe. On 10/27/2026 at 12:20 PM, Administrative D stated that she expected the MDS assessments to be completed by their due date. The facility’s “Resident Assessment and Associated Processes” policy, revised January 2023, documented each resident would be assessed every three months (at least every 92 days) between comprehensive assessments using a standardized quarterly review process.	F0638		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761		

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F0761 SS = E	Continued from page 8 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to store medications in a secure manner as required when staff left a cart with medication unlocked and unattended. Findings included: - On 10/25/2026 at 07:15 AM, Licensed Nurse (LN) I left her medication cart unlocked and unattended. The cart had seven resident containers containing insulin pens in each container in the top left drawer. There were medications and breathing treatments in the second drawer with topical medications in the third drawer and wound supplies in the bottom drawer. The bottom drawer also contained Clorox and hydrogen peroxide sanitizing wipes. On 10/27/26 at 07:15 AM, LN I stated that she knew she had left it unlocked as she had to go to the dining room for something. On 10/27/2026 at 09:50 AM, LN G stated that the nursing medication cart should be locked and laptop screens locked if the nurse is not at the medication	F0761		

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F0761 SS = E	Continued from page 9 cart and if the nurse is not in the same location that the medication cart is in. On 10/27/2026 at 12:46 PM, CDT Administrative Nurse D stated that she expected the cart to be locked if the nurse was not at the medication/treatment cart. The facility's policy "Confidentiality of Resident Information," dated 01/2025, documented the collection of resident care data, whether by interview, observation, or documents, shall be conducted in a setting which provides maximum privacy and security from unauthorized individuals.	F0761		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure accommodation of resident needs when staff failed to ensure Resident (R) 58's call light was in reach and failed to ensure R27 received the adaptive plate guard as required. Findings included: - R58's Electronic Medical Record (EMR) documented diagnoses of dementia (decline in thinking, memory, and reasoning, which is severe enough to interfere with daily life and independence), chronic kidney disease (moderate kidney damage), urinary incontinence (involuntary loss of bladder control), muscle weakness (reduced capacity of the muscles to generate normal force), and hypertension (HTN- elevated blood pressure). R58's "Admission Minimum Data Set (MDS)" dated 09/17/2026 documented a Brief Interview for Mental Status (BIMS) score of five, which indicated impaired cognition. R58 required partial to moderate assistance with transfers and staff assistance with daily tasks. R58 used a wheelchair and propelled herself around the facility.	F0558		

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F0558 SS = D	Continued from page 10 R58's "Care Plan" initiated 02/06/2023 directed staff to be sure the call light was within reach. On10/25/2026 at 07:51 AM, observation revealed R58 laid on the bed hollering out for help, with her legs hanging off the bed. The call light was clipped to the cord at the wall and outside of R58's reach. On 10/27/2026 at 09:25 AM, CNA P stated call lights should be in reach of the residents. She stated R58 cannot reach the call light where it was and said it needed to be placed where she can reach it. On 10/27/2026 at 09:31 AM, CNA Q stated call lights should be next to the residents and verified R58 needed to be able to reach her call light. On 10/27/2026 at 09:35 AM, CNA M stated call lights should be located within reach. R58 is unable to get to her light if it is not in reach. On 10/27/2026 at 09:41 AM, Licensed Nurse (LN) G stated call lights should be in reach of the resident. LN G said R58 cannot get up and get her own call light. LN G stated, "We don't want her to anyways, we hope it is always within reach." On 10/27/2026 at 10:49 AM, Administrative Nurse D states residents should always have their call light within reach. She said she was unaware if R58 could get out of bed to reach the call light but if she was in bed, it should be within reach. The policy "Reasonable Accommodation of Needs" dated revised August 2021, documents this facility to ensure that a resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered and to have a call light within reach.	F0558		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible	F0636		

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F0636 SS = D	Continued from page 11 assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.	F0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175332	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	**1100 W 15TH STREET , OTTAWA, Kansas, 66067**

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F0636 SS = D	Continued from page 12 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure Resident (R) 15's comprehensive assessment was completed in the required timeframe. Findings included: - 1. R16's Electronic Medical Record (EMR) under the Minimum Data Set (MDS) tab documented an Assessment Reference Date (ARD) date of 09/19/2026 for her "Annual MDS." The MDS and Care Area Assessments (CAA) were completed on 10/22/2026, 33 days after the ARD. 2. R27's MDS tab in the EMR documented an ARD date of 09/25/2026 for her "Annual MDS". The MDS and CAAs were completed on 10/26/2026, 31 days after the ARD. On 10/27/2026 at 11:43 AM, Administrative Nurse F stated that the facility had a new program for completing MDS, and some of them may have been started on time but were not completed and submitted by the 14-day timeframe. On 10/27/2026 at 12:20 PM, Administrative D stated that she expected the MDS assessments to be completed by the due date. The facility's "Resident Assessment and Associated Processes" policy, revised January 2023, documented comprehensive assessments will be conducted within 14 days of admission, when there is a significant change in the resident's status, and not less than once every 12 months (within 366 days of the previous comprehensive assessment).	F0636		

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F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §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 interview, the facility failed to provide the necessary supervision, assistance, and cueing required by	F0676		

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F0676 SS = D	Continued from page 14 Resident (R) 27 to promote her independence with eating. Findings included: - R27's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dyskinesia (inability to execute voluntary movements), dysphagia (swallowing difficulty), and panic disorder (anxiety that is characterized by recurrent, unexpected panic attacks accompanied by persistent worry about future episodes). R27's "Annual Minimum Data Set (MDS)" dated 09/25/2026 did not document a Brief Interview for Mental Status (BIMS) score, the assessment was documented as not assessed/no information. The MDS did not document the staff assessment for mental status and was marked as not assessed/no information. R27 required supervision or touching assistance with eating and was dependent on staff for toileting, dressing, hygiene, bed mobility, transfers, mobility when in her wheelchair and other activities of daily living (ADL). R27's "Nutrition Care Area Assessment (CAA)" dated 10/26/2026 documented R27's received a mechanically altered diet and had functional problems that affected her eating including vision problems, a need for a special diet, dementia, anxiety problems, difficulty making self-understood, difficulty understanding others, depression, and Parkinson's disease. R27's "Care Plan" initiated 10/20/2022 documented R27 had an increased risk of nutritional problems and noted she attempted to eat condiment packages. The plan documented she required set/up and clean up assistance and required supervision. The food should be served in bowls or on plates with a guard and directed staff to offer finger foods when available. R27's "Care Plan" documented she had impaired cognitive function related to Alzheimer's disease and dementia; staff were directed to use simple statements when giving verbal cues. The plan documented her food preferences were Cheerios for breakfast and finger food when available. On 10/26/2026 at 07:55 AM, R27 sat at the dining room table. R27 had no staff present near her at the	F0676		

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F0676 SS = D	Continued from page 15 table that provided her with supervision or cueing with her meal. R27 had three rectangle dishes that were small to medium in size on the table in front of her. R27 asked staff as they walked past her table for a glass of milk; they obtained a glass of milk then left the glass of milk on her table and walked away. R27, without supervision or cueing from staff, was unable to keep her spoon horizontal to eat the Cheerios from the rectangle container without a guard; most Cheerios on the spoon fell off onto the floor under and around the chair and the table where she sat. R27, without supervision or cueing from staff, placed the rectangle container of mechanically altered biscuit and gravy in her lap and was unable to get the food out of the container and onto her fork that was turned in the wrong direction for conventional manipulation of a fork. R27, without supervision or cueing, manipulated a piece of the biscuit and gravy onto the fork and raised the fork vertically with tines facing down at nose level and attempted to bite the biscuit off of the fork that was too high for her mouth to reach. This was attempted multiple times. Each time the biscuit slid off the fork and back into the container or onto the floor. On 10/26/2026 at 8:10 AM, three staff were observed in the dining room; two of the dining room nursing staff had approached R27's table a few times, stood beside her and spoke to the resident seated at the opposite end of the table that was assisted by the third staff member in the dining room. Staff walked away from the table each time without providing supervision or cues to R27 while she was having difficulty trying to eat her food. On 10/26/2026 at 08:13 AM, there were no staff present near or at the table with R27, who had picked up some of the Cheerios with her hands from the container of Cheerios as they floated in the milk. On 10/26/2026 at 08:18 AM, one of the three staff in the dining room approached the table where R27 sat. He sat on a stool near R27 and looked out the window across the room, then left the table after a few minutes without providing any assistance, supervision or cueing. On 10/27/26 at 11:12 AM, Certified Nurse Aid (CNA) M stated CNA staff knew to assist a resident if they are unable to manipulate or use a utensil for eating. CNA M said staff knew how to look at the resident's care plans and should follow the plan. On 10/27/26 at 01:24 PM, Licensed Nurse (LN) G stated that the care plan should have been followed. LN G said administrative staff should have been	F0676		

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F0676 SS = D	Continued from page 16 alerted of any need for adjustments to R27's eating ability and of her ability to use utensils or plate ware. LN G said staff should have notified the charge nurse, and the charge nurse should have notified the administrative staff with any observation they had made of a resident having difficulty eating or needing assistance needed so that it can be addressed and interventions can be initiated for that resident; if a CNA were to observe difficulty manipulating utensils or eating surfaces, they should have alerted their nurse. On 10/27/2026 at 01:15 PM, Administrative Nurse D stated that all nursing staff that assisted a resident with their meal should have followed the care plan and provided the level of assistance that they were directed to provide by the resident's care plan. On 10/27/2026 at 1:45 PM, Administrative Staff A stated residents who were care planned for supervision with prompting should receive supervision and prompting. Administrative Staff A stated staff should remain with them during meals and supervise them with prompts. Administrative Staff A said she would be initiating a performance improvement plan (PIP) for all nursing staff related to supervising and prompting cognitively impaired residents. The PIP will also address that a resident with cognitive impairment who refuses assistance is still required to have assistance offered with each meal or snack each day.	F0676		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure appropriate care and services were provided to promote edema compression care for Resident (R)27 when staff failed to follow the physician's treatment order for R27's thrombo-embolic-deterrent hose (TED hose - specialized compression stockings designed to help	F0684		

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F0684 SS = D	Continued from page 17 manage swelling of the feet/legs). Findings included: - R27's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dyskinesia (inability to execute voluntary movements), dysphagia (swallowing difficulty), and panic disorder (anxiety that is characterized by recurrent, unexpected panic attacks accompanied by persistent worry about future episodes). R27's "Annual Minimum Data Set (MDS)" dated 09/25/2026 did not document a Brief Interview for Mental Status (BIMS) score, the assessment was documented as not assessed/no information. The MDS did not document the staff assessment for mental status and was marked as not assessed/no information. R27 required supervision or touching assistance with eating and was dependent on staff for toileting, dressing, hygiene, bed mobility, transfers, mobility when in her wheelchair, and other activities of daily living (ADL). R27's "Quarterly Minimum Data Set "(MDS) dated 06/25/2026 documented R27 had a BIMS summary score of four, which indicated severe cognitive impairment. R27 required supervision or touching assistance with eating and was dependent on staff for toileting, dressing, hygiene, bed mobility, transfers, mobility when in her wheelchair, and other ADL. R27's "Care Plan" did not address the physician's order for TED hose. R27's physician's order dated 09/15/2026, documented for TED hose to the bilateral lower extremities which were to be put on every morning and taken off at bedtime. R27's EHR documented a nursing progress note dated 10/05/2026 at 11:27 AM that TED hose were not found, and presumably in laundry. R27's electronic "Medication Administration Report" (MAR) documented TED hose were applied by nursing staff each morning between 10/01/2026 and 10/04/2026. The MAR for 10/05/2026 at 06:00 AM documented the TED hose was not administered.	F0684		

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F0684 SS = D	Continued from page 18 The October 2026 MAR on the dates between 10/05/2026 and 10/25/2026 documented that TED hose was applied by nursing staff to R27's legs at 06:00 AM each morning. The October 2026 MAR documented that TED hose was removed by nursing staff from R27's legs each day between 10/01/2026 and 10/25/2026 at 07:00 PM. R27's EHR lacked evidence that R27 refused the TED hose on any date in October. On 10/25/2026 at 10:13 AM, R27 was sat in her room without TED hose on her bilateral leg. R27 wore tan ankle socks on both of her legs; there was visible swelling to her legs, above and below the ankle socks she was wearing. On 10/25/2026 at 01:32 PM, R27 was observed sitting in her wheelchair in her room wearing tan ankle socks and black lace up shoes, she had no TED hose was on her legs. On 10/26/2026 at 09:28 AM, Licensed Nurse (LN) H applied Tubi-grip sleeves (elastic tubular bandage) to R27's lower legs. LN H stated the Tubigrip sleeves were put on R27 daily and said she was not aware what compression the Tubigrip sleeves supplied. R27 had tan ankle socks put on both feet over the Tubigrip sleeves. There was visible swelling to her ankles above the ankle socks that were placed over the Tubigrip sleeves. On 10/25/2026 at 10:13 AM, R27's responsible person stated he thought R27 was supposed to be wearing compression socks and said that staff did not. R27's responsible person stated they alerted staff that R27 was supposed to be wearing compression socks. R27's responsible person then stated R27 would have them on for a couple of days and then staff would stop putting them on. On 10/27/26 at 11:12 AM, Certified Nurse Aide (CNA) M stated the CNAs put R27's Tubigrip sleeves on her legs and take them off her legs at night. On 10/27/26 at 11:24 AM, LN H stated R27 has an order for TED hose so it would be expected that R27 would have TED hose and not Tubigrip. On 07/29/2026 at 12:53 PM, Administrative Nurse D stated all nursing staff should follow the physician order and provide all treatments as the order states. The facility's physician orders policy dated 01/2025 documented it is the policy of this facility to accurately implement orders in addition to	F0684		

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F0684 SS = D	Continued from page 19 medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the residents' plan of care.	F0684		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (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.	F0732		

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F0732 SS = C	Continued from page 20 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included the required information. Findings included: - On 10/25/2026 at 07:15 AM, observation of the posted staffing sheet was dated 10/23/2026 and did not include the facility name. The daily posted staffing sheets for 12/13/2025, 04/25/2026, 06/20/2026, and 08/23/2026 lacked the facility name. During an interview on 10/28/2026 at 04:30 PM, Administrative Staff A acknowledged the name of the facility should be on the daily staffing sheets and daily staffing sheet was not current on 10/25/2026. The facility policy “Staff Posting Policy,” revised 10/20/2023, documented that it is the policy of this facility to post nurse staffing daily. Posting will be placed in a visible area for all the residents and resident families.	F0732		