STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT WICHITA, LLC	**1315 N WEST STREET , WICHITA, Kansas, 67203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 3166643, 3180708, 3696500, 3192231,3 1106668, 3698907, 3120135. The census was 90 The sample included 19 residents.	F0000		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to identify and implement measures consistent with and in accordance with professional standards of practice to prevent the development of and promote the healing of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for Resident (R) 5, who developed a facility acquired, unstageable, deep tissue injury to her right heel and acquired a stage three (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer that developed on R5's left heel. The staff failed to ensure R3's heels were offloaded and failed to ensure R5 received the required	F0686		

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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F0686 SS = G	Continued from page 1 interventions to prevent pressure ulcer development. Findings included: - R5's Electronic Medical Record (EMR) documented diagnoses of polyneuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet) and restless leg syndrome. R5's 05/27/2026"Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R5's MDS documented that he required maximal assistance with bed mobility, and he was at risk of pressure ulcer injuries. R5's MDS documented he had a pressure relieving device for his chair and bed. Additionally, R5's MDS documented that he was not on a turn and repositioning program. R5's 06/01/2026 "Pressure Ulcer/Injury Care Area Assessment" (CAA) documented R5 was at risk for pressure ulcers related to him wearing a thoracic lumbar sacral orthosis (TLSO-brace that limits movement of the spine) brace, weakness, and decreased mobility. R5's 05/22/2026 "Care Plan" instructed staff that R5 required a pressure-reducing mattress to protect his skin while in bed and a pressure-reducing cushion to protect his skin while in his wheelchair. R5's 05/22/2026 "Care Plan" directed staff to monitor R5's skin integrity weekly and as needed. R5's 06/01/2026 "Care Plan" instructed staff that R5 required substantial to maximum assist with bed mobility. R5's 06/18/2026 "Care Plan" documented that staff recommended a low air loss mattress and R5 refused, and he was educated on risk and benefit. It was documented that staff provided heel booties to R5 while he was in bed, as he would allow. The "care Plan" documented that he had skin integrity concerns concerning a surgical incision to his lumbar spine (the lower part of the back) and he had venous insufficiency (leg veins cannot effectively return blood to the heart due to weakened vein walls) to his right heel. R5's 08/11/2026 "Care Plan," documented staff provided positioning rails to his bed to assist with transfers, bed mobility, and positioning. R5's 06/18/2026 "Physician Order" documented:	F0686		

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F0686 SS = G	Continued from page 2 apply Betadine daily to the blister on the outer right heel. Discontinued date 06/29/2026. R5's 06/18/2026 "Physician Order" documented: apply Betadine daily to the blister on the left heel. Discontinued date 08/14/2026. R5's 10/31/2026 "Physician Order" directed staff to cleanse his left heel wound with wound cleanser, pat dry, apply collagen with dressing, wrap with Kerlix, and then wrap with Ace wrap. The dressing was to be changed every Tuesday, Thursday, Saturday, and as needed. R5's 05/21/2026 "Braden Scale" (scale used to predict pressure ulcer risk), dated 07/03/2026, documented a score of 17, which indicated mild risk. R5's 05/26/2026 "Braden Scale" documented a score of 18, which indicated mild risk. R5's "Braden Scale," dated 06/02/2026, 06/09/2026, 06/17/2026, and 06/23/2026, documented a score of 20, which indicated no risk. R5's "Weekly Skin Noted," dated 05/26/2026, 06/02/2026, and 06/09/2026, documented that R5 had a lower back surgical incision – no other concerns documented. R5's 06/08/2026 at 2:29 PM "Provider Note," documented both lower extremities; venous Doppler was obtained and was negative for a clot. R5's 06/17/2026 "Weekly Skin Note" documented a new area on the left heel and a blister-like area on the outer right heel. R5's 06/17/2026 "Wound Note" documented R5 had a left heel stage three pressure ulcer that measured 1.7 centimeters (cm) by 2.0 cm. Additionally, R5 had a right heel blister, unstageable, that measured 2.0 cm by 2.0 cm. It was documented that wounds were facility-acquired on 06/17/2026, treatment was ordered, and he was to wear booties to both heels when in bed. R5's 07/01/2026 "Wound Note" documented R5's right heel blister pressure ulcer stage three measured 3.8 cm by 4.7 cm and the left heel stage three pressure ulcer measured 1.6 cm by 1.8 cm. R5's left heel was scabbed over, and current treatment would continue as ordered. R5's right heel had increased drainage and measured larger in size, and new treatment orders were obtained.	F0686		

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F0686 SS = G	Continued from page 3 R5's 08/27/2026 at 12:33 PM "Provider Note," documented R5 had negative arterial/venous Doppler of his right leg. An observation on 11/02/2026 at 07:57 AM revealed R5 was not in his room; heel booties were observed on his bed, no air mattress on his bed, and he had two positioning bars on his bed. An observation on 11/02/2026 at 09:33 AM revealed R5 was seated in his wheelchair in his room; he reported that he had sores on his heels, but the right heel was healed. R5 reported that he had limited mobility of his lower legs since his first back surgery. He reported that he did not have booties for his heels until after his heels broke down. R5 reported that the facility had mentioned an air mattress and then reported that the staff told him it would not work on his bed. On 11/03/2026 at 10:29 AM, Licensed Nurse (LN) G and Certified Nurse Aide (CNA) T performed hand hygiene and applied gowns and gloves to complete wound care for R5's left heel. The left heel had an approximately 1.0 cm diameter dark discolored area with no drainage. R5 was unable to lift his heel off the bed without assistance from CNA T. On 11/04/2026 at 08:18 AM, CNA T reported that R5 had a hard time lifting his legs on his own and that he never refused any care and wore his heel booties. On 11/04/2026 at 9:05 AM, CNA M reported that R5 was first admitted as a skilled resident and that the interventions for the CNA to do it for skin prevention would be on the Kardex or care plan, she could not recall if R5 had any skin prevention interventions in place when he admitted. CNA M reported that he had a hard time lifting his legs on the bed and that R5 required assistance with bed mobility. CNA M reported that R5 did not refuse care, but sometimes he refused therapy as he had too much pain. On 11/04/2026 at 09:22 AM, Administrative Nurse E reported that initially, she was told R5 had venous stasis and that is why she documented venous insufficiency of the right heel on R5's care plan. Administrative Nurse E reported she modified R5's 06/30/2026 "End of PPS MDS" section M to the correct documentation that one stage three and one unstageable wound were not present on admission. On 11/04/2026 at 09:39 AM, Consultant Staff AA stated that the facility had reported to her that R5 had refused the air mattress but could not recall	F0686		

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F0686 SS = G	Continued from page 4 when. On 11/04/2026 at 10:52 AM, Administrative Nurse A reported that R5's wounds came out of nowhere. She reported that she completed all the wound notes and reviewed the weekly skin notes that the nurse completed to make sure nothing was missed. Administrative Nurse A reported that a weekly Braden was completed and he was walking; she reported that the mattresses at the facility are high risk mattresses on the beds, and he refused an air mattress after the wounds were discovered. Administrative Nurse A reported that she would not care plan heel booties as it did not require a doctor's order, as it would be a nursing intervention. She reported that as soon as the wounds were noted, the areas were treated. On 11/04/2026 at 04:30 PM, Consultant Staff AA reported that she reviewed R5's EMR. She reported that she had ordered several tests when R5 had edema of his lower legs and reported that the tests were negative for occluded blood flow. The facility's policy "Pressure Ulcer and Excoriation," dated 01/26/2026, documented that all patients should be assessed for skin risk upon admission using the Braden Scale by a licensed nurse and appropriate interventions put in place. Provide interventions to prevent skin breakdown and pressure injuries in patients identified as being at risk. Develop an individualized treatment plan of care designed to decrease the patient's risk for breakdown or help improve skin that has shown signs of compromise. Update the plan of care, as necessary.	F0686		
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 interview and record review, the facility failed to complete an annual performance review at least once every 12 months for five Certified Nurse Aides (CNAs) reviewed.	F0730		

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F0730 SS = F	Continued from page 5 Findings included: - Review of CNA personnel files revealed the following: CNA N, hired on 07/14/2021, lacked an annual performance evaluation. CNA O, hired on 07/22/2025, lacked an annual performance evaluation. CNA P, hired on 06/10/2025, lacked an annual performance evaluation. Certified Medication Aide (CMA) R, hired on 06/25/2024, lacked an annual performance evaluation. CMA S, hired on 08/10/2022, lacked an annual performance evaluation. On 11/04/2026 at 10:12 AM, Administrative Staff A reported that they did not have performance evaluations for the five CNAs that were requested. Administrative Staff A reported that he expected the performance evaluations to be completed annually and had already written a new policy for compliance in the future. The facility's policy "Performance Review," dated 11/004/2026, documented that our performance review program is designed to foster a better understanding between you and your department director, immediate supervisor, or facility management regarding your job performance, potential, and development within compassionate healthcare providers. Employees will receive a performance review once each year, conducted by their department director or supervisor.	F0730		
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	F0812		

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F0812 SS = F	Continued from page 6 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 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: - On 11/02/2026 at 07:40 AM, during the initial tour of the kitchen, the following areas of concern were identified: 1. The oven handle had cracks and missing pieces of plastic. 2. A black, fuzzy substance covered the return air vent behind the table used for puree. 3. The salad bar cart had signage that instructed staff to remove items after three days. The following items dated 10/28/2026 were past the removal date: diced onions, pickles, Italian dressing, ham, turkey, shredded cheese, and tartar sauce. 4. A large nonstick frying pan had charring on the exterior and peeled Teflon coating on the interior. 5. The drain that was located under the rear left side of the stove had a brown substance that was leaking into it. 6. Debris covered the sides and exhaust of the stand-alone fryer. 7. Two shelves in the refrigerator had cracks and rust. 8. There was a stack of clean plates, bowls, and plate warmers right side up on the clean side of the dishwashing area without covering.	F0812		

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F0812 SS = F	Continued from page 7 9. There was a cart in the dining room, behind the serving station, that had bowls, plates, and plate warmers right side up that was left uncovered between meal service times. On 11/03/2026 at 01:17 PM, the salad bar items had been removed; the other above areas of concern remained unchanged. On 11/03/2026 at 04:04 PM, Dietary Staff BB stated that she expected all surfaces to be clean and sanitary. She stated that all appliances were expected to be in good working order without damage. She stated a maintenance order was completed and turned in for the dirty air vent. Dietary Staff BB said the items on the salad bar cart were to be dated and then pulled after three days; staff was aware of this, and it has been posted on the cart. She stated clean dishes should have been stored inverted, and cooking pans/sheets were to be in clean working condition with no gouges or flaked coating. The facilities policy “Food Preparation and Sanitation” dated on 03/01/2026 included: The kitchen and equipment will be kept clean, neat, orderly, and well maintained. Leftover food can be stored for up to three days, with the day of preparation being day one. The facilities policy “Storage of Kitchen Utensils, Tableware and Equipment,” dated 2026, included: Cleaned and sanitized utensils and equipment will be stored at least six inches off the floor in a clean, dry location in a way that keeps them from contamination by splash, dust, or other means.	F0812		
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	F0583		

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F0583 SS = E	Continued from page 8 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 record review and interview the facility failed to ensure the staff secured and protected the privacy and confidentiality of Residents (R) 4, R58, that received dialysis care (a procedure where impurities or wastes are removed from the blood) and 50 residents to receive immunizations (a process of making a person resistant to an infectious disease), seven residents in hall 900, 25 residents in hall 100/200 hall, and 18 residents in hall 300. Confidential information for these residents was sent randomly in text communication from the facility text communication thread.Findings included: - An undated report at 11:30 AM documented the facility's group chat regarding R58's and R4's names and the scheduled dialysis days the two residents would be receiving dialysis, and was sent out to the facility staff and an individual not employed by the facility to have the residents ready for their treatment. In an undated text communication thread at 02:23 PM, the names of 50 residents and the halls they resided on were sent as a group thread to facility staff and an individual not employed by the facility. The communication documented the immunization clinics the residents were scheduled for on 10/19/26 at 01:00 PM and 10/20/2026 at 01:00 PM. On 10/23/2026 at 12:26 PM, R58's fluid restriction information was sent, via communication text, to facility staff and an individual not employed by the	F0583		

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F0583 SS = E	Continued from page 9 facility. On 11/4/2026 at 12:29 PM, Administrative Nurse D said that when a staff member was terminated, or they removed themselves from the schedule by no longer picking up shifts, they were immediately removed from the facility communication thread. If the staff member was PRN (as needed), they could not be removed for another 30 days. She said that the Assistant Director of Nursing (ADON) had recently been terminated from employment due to placing resident names and personal information on the group chat for staff. The facility's policy "Notice of Privacy Practices" documented that the facility is required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1999 (HIPAA) to maintain the privacy of each resident's medical information and to provide residents with notice of the facility's legal duties and privacy practices with respect to each resident's medical information. Protecting the confidentiality of each resident's personal information has been and always will be a top priority for this facility. The facility ensures that only employees and volunteers who need each resident's name information to perform the staff member's assigned job duties are provided with access to the president's health information.	F0583		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of	F0605		

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F0605 SS = D	Continued from page 10 resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F0605		

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F0605 SS = D	Continued from page 11 §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R) 68's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications had an appropriate indication for use, lacked non-pharmacological interventions, and lacked physician documentation justifying the antipsychotics. Findings included:	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0605 SS = D	Continued from page 12 - R68's Electronic Medical Record (EMR) documented diagnoses of psychotic disorder with delusions (a condition where prominent delusions or hallucinations are directly caused by the physical effects of a general medical, neurological, or systemic disease), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory and confusion). R68's 10/12/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R68 received an antipsychotic, an anti-anxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), a diuretic (a medication to promote the formation and excretion of urine), and opioid (a class of controlled drugs used to treat pain) medications. R68's "Psychotropic Drug Use Care Area Assessment (CAA)," dated 10/16/2026, documented she had a history of depression, bipolar disorder, and anxiety and received risperidone (antipsychotic medication) and quetiapine (antipsychotic medication), anti-anxiety medication alprazolam, and sertraline (an antidepressant). A gradual dose reduction (GDR) was contraindicated at this time due to the risk of psychiatric decompensation, recurrence of psychotic symptoms, mood destabilization, and decline in overall functioning. R68's "Care Plan," revised on 08/03/2026, directed staff to administer medications as directed, monitor and document for side effects and effectiveness, attempt a GDR per physician orders, and she took an antipsychotic medication for anxiety. R68's "Orders" tab of the EMR documented a physician's order dated 10/27/2025 for risperidone 0.5 milligrams (mg) by mouth at bedtime for bipolar disorder. This order lacked an approved indication and lacked non-pharmacological interventions. R68's "Orders" tab in the EMR documented a physician's order dated 10/27/2025 for quetiapine fumarate 50 mg by mouth every 12 hours for bipolar disorder. The order lacked an approved indication	F0605		

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F0605 SS = D	Continued from page 13 and lacked non-pharmacological interventions. On 11/03/2026 at 11:35 AM, R68 sat in her wheelchair in the assisted dining area with staff seated beside her. On 11/04/2026 at 12:11 PM, Administrative Nurse D stated the physician should have provided an appropriate diagnosis for an antipsychotic medication and any non-pharmacological interventions and documentation to justify its use. The facility's "Unnecessary Drugs and Psychotropic Drugs" policy dated 03/01/2026 documented that each resident's drug regimen must be free from unnecessary drugs, defined as any drug used: in excessive dose (including duplicate drug therapy); for excessive duration; without adequate monitoring; without adequate indications for use; in the presence of adverse consequences that indicate the dose should be reduced or discontinued; or any combination of the above.	F0605		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F0690		

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F0690 SS = D	Continued from page 14 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) related care for Resident (R) 77 when staff did not ensure his catheter was changed every 30 days per the physician's order. Additionally, the facility failed to ensure R77, with a symptomatic urinary tract infection (UTI), received timely and appropriate antimicrobial therapy as indicated by the urine culture and sensitivity results for three days, which resulted in delayed treatment for a confirmed bacterial infection. Findings included: - R77's Electronic Medical Record (EMR) documented diagnoses of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). R77's 12/30/2025 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R77's MDS documented that she required total assistance with toileting hygiene and had an indwelling catheter. R77's 01/06/2026 "Urinary Indwelling Catheter Care Area Assessment" (CAA) documented R77 was a dependent assist with toileting and had a foley catheter in place that was present upon admission. Staff would perform catheter care every shift and as needed. R77's "Care Plan," dated 12/26/2025, instructed staff to monitor, record, and report to the provider any signs or symptoms of a UTI (pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, and/or foul-smelling urine). R77's "Care Plan," dated 01/07/2026, instructed	F0690		

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F0690 SS = D	Continued from page 15 staff to change the catheter as ordered. R77's 06/06/2026 "Physician Orders" documented that staff were to replace the indwelling Foley catheter and closed system with collection bag every four weeks and as needed, every day shift, every 30 days for neurogenic bladder. R77's 07/29/2026 "Physician Orders," documented staff were to change the foley catheter and obtain a urinalysis for culture and sensitivity immediately, one time for UTI symptoms, date completed, 07/29/2026. R77's 08/03/2026 "Physician Orders" documented Ciprofloxacin (antibiotic) 250 milligram (mg), give one table by mouth every 12 hours a day for UTI for five days. R77's 07/29/2026 at 10:28 AM "Progress Note" documented staff had received new orders from Consultant Staff GG to change the foley catheter and obtain an immediate urinalysis for culture and sensitivity. R77's 07/30/2026 at 11:12 AM "Provider Note" documented R77 was seen per nursing request due to increased fatigue and a purple catheter bag. Nursing staff reported that his urine is very malodorous (having a bad, unpleasant, or offensive smell). R77 reported that he did not have a good night and did not sleep well. R77's 07/31/2026 at 04:24 AM "Progress Note" documented that the urinalysis with culture and sensitivity was received and given to team health for review. R77's 07/31/2026 at 11:52 AM "Progress Note" documented lab reports were received from the lab that were obtained on 07/29/2026 at 03:00 PM for urinalysis and culture and were placed into the team health box. R77's 08/03/2026 at 12:15 PM "Provider Note" documented that R77 was seen for follow-up of his recent urinalysis and urine culture results. His urine culture was positive for Escherichia coli (E. coli-bacteria commonly found in the lower intestine that had the potential to cause infections in the urinary tract with inadequate incontinence care) with susceptibility to Ciprofloxacin. R77 denied fever, chills, flank pain, nausea, or vomiting but continued to have urinary symptoms consistent with a urinary tract infection.	F0690		

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F0690 SS = D	Continued from page 16 R77's 09/14/2026 at 12:27 PM "Progress Note" documented the old catheter was removed and replaced with a sterile catheter. The urine was clear yellow after placement, and R77 denied pain or discomfort. Review of R77's EMR and Electronic Treatment Administration Record (ETAR) lacked documentation that R77 had his Foley catheter changed from 09/14/2026 to 11/04/2026. On 11/02/2026 at 11:50 AM, R77 was in his bed and there was a smell of strong urine, he had his eye closed and opened them when he heard his name. R77's catheter bag was not covered that hung on his bed; the drainage bag was discolored blue/black in color. On 11/03/2026 at 09:31 AM, R77 was seated in his wheelchair in his room, and his discolored drainage bag hung on a dressing stick below his bladder; there was a strong urine odor in his room. He reported that he emptied the drainage bag by himself. On 11/04/2026 at 08:41 AM, no strong urine smell was observed in R77's room. R77 self-propelled himself out of his room to the dining room with his discolored drainage bag on the side of his wheelchair. On 11/04/2026 at 08:32 AM, Licensed Nurse (LN) G reported that culture and sensitivity would be completed before an antibiotic would be ordered by a provider. LN G reported that once we received the lab results back, the nurse was to call the provider immediately to update them on the results. LN G reported that the Foley catheters were changed every 30 days and as needed. LN G reported that the ETAR would let the nurse know when the catheter was due to be changed. On 11/04/2026 at 09:05 AM, Certified Nurse Aide (CNA) M reported that R77 would empty his own drainage bag and housekeeping would clean his room daily and sometimes twice a day as he would spill his urine. CNA M reported that he did not allow the staff to assist him much, as he liked to do his own care. She reported that he was care planned to refuse a dignity bag and that he would use his dressing stick to hold and move the catheter bag around. On 11/04/2026 at 09:12 AM, LN H reported that she would look at the orders for a foley catheter change and most were ordered to be changed every 28 days	F0690		

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F0690 SS = D	Continued from page 17 and as needed. LN H reported the order was to be documented on the ETAR when the Foley catheter was due for a change. LN H opened R77's orders and reported that it was not scheduled to show on the ETAR, and then LN H updated the order so the order would be on the ETAR. LN H reported that when a urine culture and sensitivity report was obtained from the lab, the nurse was to send the results to the provider via fax or call them with all the results and get an order for an antibiotic right away. On 11/04/2026 at 09:39 AM, Consultant Staff GG reported that she expected a resident to be treated with an antibiotic once a urine culture and sensitivity was received from the lab. Consultant Staff GG reported that she expected the staff to change the resident's Foley catheter as ordered. On 11/04/2026 at 11:01 AM, Administrative Nurse D reported that she expected the residents to have their Foley catheter changed per the order and as needed. Administrative Nurse D reported that the order was on the ETAR for the nurse to know when the catheter was due for a change. Administrative Nurse D reported that she expected the residents to have a urine culture and sensitivity treated by the provider as soon as the results were sent to the provider. On 11/04/2026 at 04:30 PM, Consultant Staff GG reported that she reviewed R77's EMR and stated that the culture and sensitivity was received on a Friday and she expected the staff to call the on-call provider to obtain orders so no delay in treatment occurred. Consultant Staff GG reported that she was on call that weekend and no nurse called to update her with the culture and sensitivity results for R77. The facility did not provide a policy for Foley catheter change, treatment of a urinary tract infection, or following a physician order.	F0690		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0698		

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F0698 SS = D	Continued from page 18 Based on observation, record review, and interview, the facility failed to ensure that information regarding where and when Resident (R) 4 went out of the facility for her dialysis (a procedure where impurities or wastes are removed from the blood) treatments were provided by the outside facility care agency. Findings included: - R4's Electronic Medical Record (EMR) documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on renal dialysis (a medical treatment that filters waste products, excess fluids, and toxins from the blood when a person's kidneys can no longer perform these functions). R4's "Significant Change Minimum Data Set (MDS)," dated 04/23/2026, documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R4 received dialysis services. R4's "Functional Abilities Care Area Assessment (CAA)," dated 04/16/2026, documented she required partial to moderate assistance with activities of daily living (ADLs), she was a dependent assist with her transfers and was independent with her wheelchair mobility. She received services through an outside agency. She was alert and oriented times four with confusion at times, and she was able to make her needs known to staff, and they provided assistance as needed. R4's "Care Plan," revised on 10/01/2025, directed staff that she received dialysis. Staff were instructed that the charge nurse would check for bruit (blowing or swishing sound heard when blood flows through a shunt) and thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's shunt) every shift. If bleeding occurred, staff were instructed to apply pressure, yell for help and do not leave the resident alone. Staff were directed to communicate R4's condition with dialysis per the written communication form with each resident dialysis visit and as necessary. R4's dialysis communication sheet was to be sent on dialysis days; dialysis may not send the communication sheet back. Staff were informed that she had a fluid restriction of 1,500 milliliters (mL)/24 hours, and they were to monitor R4 for signs and symptoms of shortness of breath or increased edema, and report this to the doctor; monitor labs as ordered and monitor her shunt site	F0698		

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F0698 SS = D	Continued from page 19 daily for signs and symptoms of infection such as redness, edema, or drainage. On dialysis days, the facility may administer medications, treatments, and accu-checks upon arrival back to the facility and report signs and symptoms of infection to the physician. R4 to receive dialysis three times a week. R4's Care Plan lacked staff direction on where her dialysis clinic was, the dialysis clinic contact information, what days she went, and what her chair time was, and how she would be transported to her appointments. R4's "Orders" tab of the EMR documented a physician's order dated 05/11/2026 for dialysis on Monday, Wednesday, and Friday. R4 would be transferred by her outside care agency. The order lacked information on the dialysis clinic name, location, or contact information. On 11/03/2026 at 08:15 AM, R4 sat in her wheelchair in the dining room. R4 stated that she went very early to dialysis. She said her outside care agency staff came to get her ready and transport her. On 11/04/2026 at 10:53 AM, Licensed Nurse (LN) H stated that R4 went to dialysis early in the morning before her shift started. LN H stated R4's order in the EMR for dialysis said she went on Monday, Wednesday, and Friday and did not say where she went for her dialysis. LN H stated R4's care plan should have some type of information about the dialysis clinic and about her chair time. On 11/04/2026 at 11:15 AM, Administrative Nurse D stated that R4 received care from an outside agency. Administrative Nurse D stated this outside agency had been reluctant to divulge information about where and what time R4 went for dialysis despite repeated requests to the agency to provide the information. Administrative Nurse D stated the outside agency came to the facility early in the morning and got R4 ready and then transported her to her dialysis appointments. Administrative Nurse D stated R4's care plan should let staff know where she went for dialysis, as well as when her chair time was and the dialysis clinic contact information. The facility's "Hemo-Dialysis Policy," dated 12/07/2023, documented care planning may include items from the list below as needed. Incorporate dialysis center protocols; coordination between the facility and the involved certified dialysis center; the care plan will reflect consistency with the resident's specific condition, goals, risks, needs, behaviors, and preferences, and current standards of practice,	F0698		

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F0698 SS = D	Continued from page 20 with measurable goals and timetables with specific interventions related to dialysis services and end-stage renal disease; and who provides transportation to/from the dialysis center.	F0698		
F0742 SS = D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a physician recommended psychiatric referral for Resident (R) 68 was completed. Findings included: - R68's Electronic Medical Record (EMR) documented diagnoses of psychotic disorder with delusions (a condition where prominent delusions or hallucinations are directly caused by the physical effects of a general medical, neurological, or systemic disease), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory and confusion). R68's 10/12/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R68 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an anti-anxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), a diuretic	F0742		

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F0742 SS = D	Continued from page 21 (a medication to promote the formation and excretion of urine), and opioid (a class of controlled drugs used to treat pain) medications. R68's "Psychotropic Drug Use Care Area Assessment (CAA)," dated 10/16/2026, documented she had a history of depression, bipolar disorder, and anxiety and received risperidone (antipsychotic medication) and quetiapine (antipsychotic medication), anti-anxiety medication alprazolam, and sertraline (an antidepressant). A gradual dose reduction (GDR) was contraindicated at this time due to the risk of psychiatric decompensation, recurrence of psychotic symptoms, mood destabilization, and decline in overall functioning. R68's "Care Plan," revised on 08/03/2026, directed staff to administer medications as directed, monitor and document for side effects and effectiveness, attempt a GDR per physician orders, and that she took an antipsychotic medication for anxiety. R68's EMR documented on 04/01/2026 at 04:08 PM a "Provider Encounter" progress note for her to have a referral to a psychiatric nurse practitioner for management of her medications, as she was no longer on hospice. R68's EMR documented on 06/03/2026 at 01:53 PM a "Provider Encounter" progress note for a referral to a psychiatric nurse practitioner for management of her medications, as she was no longer on hospice. On 11/03/2026 at 11:35 AM, R68 sat in her wheelchair in the assisted dining area with staff seated beside her. On 11/04/2026 at 08:24 AM, Administrative Nurse D stated the facility missed getting that psychiatric consult completed for R68. Administrative Nurse D stated a night shift nurse had documented the physician's documentation and was not aware that they needed to communicate that order to social services. Administrative Nurse D stated that the psychiatric consult was overlooked a second time and she missed it, but yes, the consult should have been scheduled and completed. The facility's "Physician Services" policy, dated 10/08/2023, lacked documentation about the facility's responsibility to complete physician orders or referrals.	F0742		

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F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported when Resident (R) 68 did not have an approved indication for use of her antipsychotic (a class of medications used to treat major mental conditions that cause a	F0756		

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F0756 SS = D	Continued from page 23 break from reality) medications and lacked non-pharmacological interventions and lack physician documentation justifying the antipsychotics. The facility failed to ensure R55 had documentation that a Monthly Regimen Review (MRR) had been completed. Findings included: - R68's Electronic Medical Record (EMR) documented diagnoses of psychotic disorder with delusions (a condition where prominent delusions or hallucinations are directly caused by the physical effects of a general medical, neurological, or systemic disease), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory and confusion). R68's 10/12/2026 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R68 received an antipsychotic, an anti-anxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), a diuretic (a medication to promote the formation and excretion of urine), and opioid (a class of controlled drugs used to treat pain) medications. R68's "Psychotropic Drug Use Care Area Assessment (CAA)," dated 10/16/2026, documented she had a history of depression, bipolar disorder, and anxiety and received risperidone (antipsychotic medication) and quetiapine (antipsychotic medication), anti-anxiety medication alprazolam, and sertraline (an antidepressant). A gradual dose reduction (GDR) was contraindicated at this time due to the risk of psychiatric decompensation, recurrence of psychotic symptoms, mood destabilization, and decline in overall functioning. R68's "Care Plan," revised on 08/03/2026, directed staff to administer medications as directed, monitor and document for side effects and effectiveness, attempt a GDR per physician orders, and she took an antipsychotic medication for anxiety. R68's "Orders" tab of the EMR documented a	F0756		

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F0756 SS = D	Continued from page 24 physician's order dated 10/27/2025 for risperidone 0.5 milligrams (mg) by mouth at bedtime for bipolar disorder. This order lacked an approved indication and lacked non-pharmacological interventions. R68's "Orders" tab in the EMR documented a physician's order dated 10/27/2025 for quetiapine fumarate 50 mg by mouth every 12 hours for bipolar disorder. The order lacked an approved indication and lacked non-pharmacological interventions. Review of the monthly "Consultant Pharmacist Recommendations to Physician" in the EMR from October 2025 to October 2025 lacked the identification and reporting of R68's inappropriate indication for use of antipsychotic medications risperidone and quetiapine. On 11/03/2026 at 11:35 AM, R68 sat in her wheelchair in the assisted dining area with staff seated beside her. On 11/04/2026 at 12:11 PM, Administrative Nurse D stated she would expect the CP to identify and report to the physician when a resident had an inappropriate diagnosis for an antipsychotic medication. - R55's EMR documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), type 2 diabetes mellitus (DM , hypertension (HTN elevated blood pressure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), chronic kidney disease (CKD - a long-term condition where the kidneys are damaged or unable to filter blood effectively), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R55's "Admission MDS," dated 08/25/2026, documented a BIMS score of eight, which indicated moderately impaired cognition. R55 received an anti-anxiety medication, an antidepressant , an antipsychotic , a diuretic, and an opioid medication. R55's "Psychotropic Drug Use CAA," dated 08/26/2026, documented that she had a history of depression, anxiety, and schizophrenia and received	F0756		

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F0756 SS = D	Continued from page 25 medications to treat those diagnoses. She had remained free from adverse effects of antidepressant, anti-anxiety medication, and antipsychotic medication use, and staff were to monitor for adverse effects of medication use every shift. R55's "Care Plan," revised on 08/26/2026, directed staff to administer medications as ordered, monitor and document side effects and effectiveness, and consult with the pharmacy and physician to consider dosage reduction when clinically appropriate. R55's EMR lacked documentation for any MRR from the CP since her admission. On 11/03/2026 at 07:35 AM, R55 sat in the facility entry lobby awaiting to be picked up to go to her outside facility program center. On 11/04/2026 at 11:10 AM, Administrative Nurse D stated that R55 was a resident that had an outside facility program that handled all her medications, getting her to appointments, etc. The facility has tried numerous times and requested this agency to send all communications regarding her medications and appointments. Administrative Nurse D said the facility still had not received any pharmacy recommendations or any requested information t regarding R55. The facility's "Unnecessary Drugs and Psychotropic Drugs" policy dated 03/01/2026 documented that a licensed pharmacist would review each resident's drug regimen at least monthly. The pharmacist will report any irregularities to the attending physician and the Director of Nursing. Identified issues will be acted upon and documented in the clinical record. Each resident's drug regimen must be free from unnecessary drugs, defined as any drug used: In excessive dose (including duplicate drug therapy); for excessive duration; without adequate monitoring; without adequate indications for use; in the presence of adverse consequences that indicate the dose should be reduced or discontinued; or any combination of the above.	F0756		