STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175187	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Health and Wellness	6501 W 75th Street Overland Park, KS 66204

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. The facility identified a census of 58 residents. The sample included 14 residents, with 14 residents. Based on observation, record review, and interviews, the facility failed to include Resident (R) 34 or her representative in the development and planning of the resident's care plan. This deficient practice placed R34 at risk of impaired care and decreased autonomy. Findings included: - R34's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (swallowing difficulty), and aphasia (condition with disordered or absent language function). The Annual Minimum Data Set (MDS) dated 02/12/25 documented R34 had severely impaired cognition. The MDS documented R34 had received hospice services during the observation period. The Quarterly MDS dated 05/13/25 documented R34 had severely impaired cognition. The MDS documented R34 had received hospice services during the observation period. R34's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/17/25 documented she had received hospice services for additional supportive care. R34's Care Plan, dated 09/12/24 documented the facility would work cooperatively with hospice team to ensure her spiritual, emotional, intellectual, physical, and social needs were met. Review of R34's EMR lacked documentation of a care plan meeting was provided and who attended the care conference for the past 12 months. The facility was able to provide a copy of a letter sent to R34's representative on 01/30/25 and 05/16/25. The EMR lacked a IDT- Care Plan Review documented under the Assessment tab. On 06/25/25 at 09:47 AM, R34 was asleep as she sat reclined in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the activity room. On 06/24/25 at 09:04 AM, R34's legal representative stated he was her representative and he was not aware of any care conference or care plan meetings that had been held for R34. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 01:52 PM, Social Services Staff X stated she scheduled the care plan meeting off the MDS schedule. Social Services Staff X stated she did not have an answer to why R34 had no documentation that a care plan had taken place in the past 12 months. Social Services Staff X stated she would complete the IDT- Care Plan Review assessment after the care plan meeting. On 06/26/25 at 02:50 PM, Administrative Nurse D stated her, or her assisted director of nursing should attend the resident's care plan meetings. Administrative Nurse D stated she had not attended any care plan meetings at this time, but she had just taken that position in the last 2 weeks. Administrative Nurse D stated the IDT- Care Plan Review assessment should be completed after each care plan meeting. The facility's Care Planning-Interdisciplinary Team policy last revised 03/2025 documented the interdisciplinary team is responsible for the development of resident care plans. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. If it was determined that participation of the resident or representative was not practicable for development of the care plan, an explanation is documented in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 3 had been assessed for the ability to self-administer her physician-ordered Voltaren gel (a pain-relieving gel). This placed R3 at risk of unsafe medication administration and adverse effects. Findings included: - R3's Electronic Medical Record (EMR) documented diagnoses of embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream) of the deep veins of the right lower extremity, malignant neoplasm (an abnormal growth of cells that has the potential to invade and destroy nearby tissues or spread to distant parts of the body) of the breast, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and diabetic neuropathy (nerve damage caused by diabetes, often leading to pain, numbness, and tingling, particularly in the hands and feet). R3's Annual Minimum Data Set (MDS) dated 10/16/24 documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R3 used a wheelchair to assist with mobility. R3 required supervision to partial/moderate assistance from staff for her activities of daily living (ADL). R3 had a urinary ostomy (surgical opening from an area inside the body to the outside) and was always continent of bowel. R3's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/21/24 documented she was at risk for alteration of her functional abilities and complications from decreased mobility related to her current diagnoses. R3 had an 11-day hospitalization. R3 required one staff and partial/moderate assist for toilet hygiene, bathing, upper and lower body dressing, and transfers from bed to chair. R3 utilized a manual wheelchair for mobility. R3's Care Plan last revised on 04/04/25 directed staff to administer medication as ordered for neuropathy; observe for adverse effects and report to the physician as needed. R3's Care Plan lacked staff direction on self-administration of her physician-ordered Voltaren. R3's Order Summary Report in the EMR documented a physician's order dated 12/30/24 for Voltaren external gel one percent (1%) to apply topically to the affected joints every six hours (6) hours as needed for pain. Use two (2) grams (gm) of unsupervised self-administration. May leave medication at the bedside. R3's Assessments tab of the EMR lacked an assessment for Self-Administration of Medications. On 06/25/25 at 10:06 AM, R3 stated she has had her Voltaren gel in her room since it had been ordered, and she applied it herself when she needed to. R3 stated she had never been assessed to self-administer the medication that she could recall. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that any resident who had an order that included self-administration should first be assessed to ensure the safe administration of the medication. LN G could not state whether R3 had been assessed for the safe administration/application of the Voltaren. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 02:06 PM, Administrative Nurse E stated that it had been noticed after a Self-Administration Assessment was requested by the nursing facility surveyor (NFS), that an assessment had not been completed for R3 to be able to safely administer her Voltaren. Administrative Nurse E stated that he had completed the self-administration assessment of R3 this morning. The facility policy Self-Administration of Medications dated 01/25, documented the clinician would provide an opportunity for the patient to administer his/her own medications. The clinician would: teach the patient the purpose and side effects of medications and the patient's role in identifying and preventing medication errors; assist the patient in setting up the medications for the first time; assess the patient' ability to self-administer medications correctly and document the patient's response and understanding to teaching; answer questions/concerns expressed by the patient and the family/caregiver regarding the patient's self-administration of medications; document the information given to the patient regarding the medication, date, and time medications was to be given, teaching the side effects, and any pertinent observations made, in the patient's clinical record, as appropriate.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. The facility identified a census of 58 residents. The sample included 14 residents. Three residents were sampled for reasonable accommodations of needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 13, R12, and R57 call lights were within their reach. This deficient practice left R13, R12, and R57 vulnerable to unmet care needs due to the inability to call for staff assistance. Findings Included: - On 06/24/25 at 07:00 AM, an inspection of R13's (vulnerable resident unable to self-transfer) laid on her bed, R13's call light lay on the over-the-bed table. R13's over-the-bed table was pushed away from her. She was unable to reach her call light. On 06/24/25 at 07:40 AM, R12 (a cognitively impaired, unable to transfer herself) was asleep on the bed with her lower extremities off to the left side of the bed. R12's indwelling urinary catheter drainage bag with dark amber urine laid directly on the floor facing the entrance door to the room. R12's call bell was on the bedside table, which was out of her reach. On 06/25/25 at 07:18 AM, R57 (an impaired resident unable to transfer himself) laid on his bed in a low position, no call bell was noted. On 06/25/25 at 07:18 AM, R12 laid asleep on her bed, and her call bell was out of her reach. The call bell was provided by the facility due to the facility's call light had stopped functioning on 04/21/25. R was on the bedside table. R12's bedside table was outside her reach. R12's soft call light with the bright-colored tape was not present. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated call bells should always be within the reach of each resident. LN G stated that nursing was rounding on residents often since the call light system was not working. On 06/26/25 at 01:28 PM, Certified Nurse Aide (CNA) M stated staff were expected to ensure the call bells were within the resident's reach. CNA M stated staff were rounding frequently on residents since call lights had been down. On 06/26/25 at 02:04 PM, Administrative Nurse D staff were expected to ensure the residents had access to their call bells. She stated staff were checking residents every 30 minutes and ensuring the call bells were within the residents' reach. The facility did not provide an accommodation of needs policy specific to call lights.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. The facility reported a census of 58. Based on observations, record reviews, and interviews, the facility failed to resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being. Findings Included: - A review of the facility's Resident Council Minutes from 06/24 through 06/25 indicated the council had recurring concerns with the food choices, menus, temperatures, and availability. The minutes also noted concerns related to maintaining and cleaning the shower rooms. The Resident Council Minutes for 07/22/24 noted under new business concerns, facility staff were not following the resident bathing schedules. The minutes indicated staff would walk into the room, turn off the call light, and exit the room. The form's staff response indicated staff were educated on following the shower schedule and call light response. The Resident Council Minutes for 08/12/24 noted under new business concerns that facility staff were still not following the resident's bathing schedule. The Resident Council Minutes for 08/12/24 noted under old business concerns that facility staff were not following the resident's bathing schedule. The Resident Council Minutes for 04/14/25 noted concerns that residents were not getting their showers completed on their assigned shower days. The form noted the residents were being told: Staff were too busy to give shower. The form's response section indicated the shower schedules were reviewed to verify preferences due to discrepancies between preferences and scheduled dates. The Resident Council Minutes for 05/12/25 noted under concerns that call lights and resident cares were not being completed in a timely manner. The Resident Council Minutes for 06/09/25 noted under concerns the council reported call lights were not being answered within a reasonable timeframe. The form's staff response indicated staff were educated on answering the call light within a reasonable time and to communicate with the resident if they need more time while assisting others. On 06/24/25 at 02:00 PM, the Resident Council stated ongoing concerns related to call light response times and following the bathing schedules. The council reported ongoing issues related to low weekend and evening staffing. The council reported repeated concerns related to being told by staff that the facility did not have enough staff to complete care tasks. On 06/26/25 at 01:11 PM, Activities Staff Z stated the council reported issues on the completed forms, and the forms were turned into the designated department for review. She stated that each department was responsible for responding to the concerns, and the designated person would report back to the council with their answers. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/26/25 at 01:30 PM, Administrative Nurse E stated staff were expected to follow the bathing schedules for each resident and to answer the call lights within a reasonable amount of time. He stated staff were expected to ensure the call lights remained within reach and functional. On 06/26/25 at 01:30 PM, Administrative Staff A stated the facility had an ongoing issue with staff telling the residents that the facility did not have enough staff to complete care. She stated the facility had educated staff about the correct level of staff required to care for each resident. The facility's Resident Council policy 06/2025 indicated the facility will provide communication between the council and designated staff. The policy noted the facility would respond and address issues reported by the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 58 residents. The sample included 14 residents, with three residents reviewed for hospitalization and/or discharge. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 19 and his representative were provided with a bed hold policy that included the facility's per diem rate to hold a bed. The facility failed to ensure R19, and his representative was provided a written notification of transfer upon his transfer to the hospital. The facility failed to ensure that a discharge summary and a recapitulation of stay were completed upon R61's discharge from the facility. This placed R19 and R61 at risk of miscommunication between the facility and the resident's representative, and the possible missed opportunity for healthcare services. Findings included: - R19's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN- elevated blood pressure), cirrhosis (chronic degenerative disease of the liver) of the liver, carcinoma (cancer that forms in epithelial tissue) of the liver, and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R19's Discharge Minimum Data Set (MDS) dated 02/08/25 documented an unplanned discharge to an acute hospital with a return anticipated. R19's Entry MDS dated 02/12/25 documented a re-entry to the facility from an acute hospital. The facility failed to provide a written notification of transfer and a bed hold policy to R19 and his representative prior to his transfer to the hospital on [DATE]. R19's Discharge MDS dated 03/07/25 documented an unplanned discharge to an acute hospital with a return anticipated. R19's Entry MDS dated 03/12/25 documented a re-entry to the facility from an acute hospital. The facility failed to provide a written notification of transfer and a bed hold policy to R19 and his representative prior to his transfer to the hospital on [DATE]. R19's Discharge MDS dated 5/12/25 documented an unplanned discharge to an acute hospital with a return anticipated. R19's Entry MDS dated 05/15/25 documented a re-entry to the facility from an acute hospital. The facility failed to provide a bed hold policy to R19 and his representative prior to his transfer to the hospital on [DATE]. R19's Annual MDS dated 06/03/25 documented he had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R19 used a wheelchair to assist with mobility. R19 required partial assistance from staff with toileting and bathing. R19 did not have an active discharge plan in place for the resident to return to the community. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/10/25 documented he had severely impaired cognition. R19 has had a recent hospitalization due to acute illnesses. R19 required partial assistance from staff for toileting and bathing. R19 planned to remain at the facility. R19's Care Plan, last revised on 05/16/25, directed staff that R19 intended to remain in the facility for long-term care (LTC). The Care Plan directed staff to assist him with discharge plans if the current LTC plans change. The Care Plan directed staff to review the discharge plan with R19 as needed. On 06/25/25 at 07:18 AM, R19 propelled himself in his wheelchair to the dining room. On 06/26/25 at 01:51 PM, Social Services X stated it had been her understanding that a new bed hold did not have to be completed upon the transfer to the hospital since a bed hold was completed at admission. Social Services X stated that they had completed the Confirmation of Transfer & Bed Hold Provision part of the facility's Bed Hold/Discharge Notification form. The facility's Bed Hold revised, on January 2025, documented that the resident, or the resident's representative shall be informed in writing of their right to exercise the bed hold provision of 10 days upon admission and provide a second notice before transfer from the facility to a general acute care hospital or at the start of a resident's therapeutic leave. In the event of an emergency transfer, the second notice would be provided within 24 hours. The notice shall include: the duration of the state bed-hold policy; the amount required to be paid by the resident or by the resident's payor source to hold the bed for the duration of the bed-hold period; that insurance may or may not cover such costs and, accordingly, the resident may have some liability for payment of uncovered costs; and the facility's policy regarding bed-hold periods permitting the resident to return. The information shall be provided to the resident and/or his/her representative in a language they could understand. - R61's Electronic Medical Record (EMR) documented diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and hypertension (HTN- elevated blood pressure). The EMR documented R61 admitted the facility on 05/02/25 and discharged the facility on 05/09/25. R61's admission Minimum Data Set (MDS) had not been completed. R61's Care Area Assessment (CAA) had not been completed. R61's Care Plan initiated on 05/05/25, directed staff to establish a pre-discharge plan with the resident, family/caregivers, and evaluate the progress and revise the plan as needed. An Orders Note scanned into R61's Misc. tab of the EMR documented an order to admit R61 for respite stay from 05/02/25 to 05/17/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R61's Discharge Note dated 05/09/25 at 02:13 PM, documented the writer had been notified that R61 was approved for another facility and wanted her transferred today. The interdisciplinary team (IDT) was notified of the discharge request. R61's spouse picked up her belongings. R61's spouse received her medications from the charge nurse. R61's spouse voiced his appreciation to the staff and for the care R61 received while at the facility. A review of R61's EMR revealed that a Discharge Summary had not been completed by staff that included a recapitulation of the stay. On 06/26/25 at 02:09 PM, Administrative Nurse E stated that typically a discharge summary would be completed upon a resident's discharge, but in R61's case, it was a sudden discharge, so it had not been completed as it should. Administrative Nurse E stated R61 was transferred to the new facility, and her medications were provided. The facility's Discharge Summary policy dated April 2025, documented when the facility anticipated a resident's discharge, the discharge summary shall include, but not be limited to the following: A recapitulation of the resident's stay that included, but was not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. A final summary of the resident's status; a reconciliation of all pre-discharge medications with the resident's post-discharge medications; a post-discharge plan of care that was developed with the participation of the resident and, with the resident's consent, the resident representative(s), which would assist the resident to adjust tohis or her new living environment. The post-discharge plan of care shall indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and non-medical services. A final summary of the resident's status at the time of discharge would be filed in the resident's medical record and be available for release to authorized persons and agencies, with the consent of the resident or the resident's representative.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition The facility identified a census of 58 residents. The sample included 14 residents, with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to identify a significant change in the physical condition and complete a comprehensive Significant Change Minimum Data Set (MDS) for Resident (R) 34 with the discharge from hospice services. This deficient practice placed R34 at risk for unidentified care needs. Findings included: - R34's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (swallowing difficulty), and aphasia (a condition with disordered or absent language function). The Annual Minimum Data Set (MDS) dated 02/12/25 documented R34 had severely impaired cognition. The MDS documented R34 had received hospice services during the observation period. The Quarterly MDS dated 05/13/25 documented R34 had severely impaired cognition. The MDS documented R34 had received hospice services during the observation period. R34's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/17/25, documented she had received hospice services for additional supportive care. R34's Care Plan, dated 09/12/24, documented the facility would work cooperatively with hospice team to ensure her spiritual, emotional, intellectual, physical, and social needs were e met. R34's EMR under the Orders tab revealed the following physician orders: Admit to hospice services with the diagnosis of senile degeneration (cognitive decline associated with old age), dated 04/18/25. On 06/25/25 at 09:47 AM, R34 was asleep as she sat reclined in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the activity room. On 06/24/25 at 09:04 AM, R34's legal representative stated R34 had been discharged from hospice services in the past month. On 06/26/25 at 07:10 AM, Licensed Nurse (LN) H was unable to locate R34's hospice communication book. LN H stated she had not had to use R34's hospice communication book recently and would not know who would have R34's hospice communication book this early in the morning. LN H stated that the social services staff may be able to help locate it. On 06/26/25 at 07:20 AM, Social Services Staff X stated R34 had been discharged from hospice services on 05/20/25. Social Services Staff X stated she was not sure why there was a current order for hospice services for R34 that was still active. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 09:10 AM, Administrative Nurse F stated she had not been notified that R34 had been discharged from hospice services on 05/20/25. Administrative Nurse F stated she had heard that R34 was to be discharged from hospice services, but there was never an order written by the physician. Administrative Nurse F stated she had initiated a Significant Change MDS this week related to R34's discharge from hospice. On 06/26/25 at 02:50 PM, Administrative Nurse D stated she would expect hospice would communicate and work with the facility. Administrative Nurse D stated she would expect the hospice services to provide the discharge order. Administrative Nurse D stated she was the person responsible for ensuring there was collaboration between the hospice provider and the hospice provider. The facility was unable to provide a policy-related MDS.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 3's Care Plan had been revised to direct staff that she was safe to self-administer her physician-ordered Voltaren gel (a pain-relieving gel). This placed R3 at risk of unsafe medication administration and adverse effects. Findings included: - R3's Electronic Medical Record (EMR) documented diagnoses of embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream) of the deep veins of the right lower extremity, malignant neoplasm (an abnormal growth of cells that has the potential to invade and destroy nearby tissues or spread to distant parts of the body) of the breast, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and diabetic neuropathy (nerve damage caused by diabetes, often leading to pain, numbness, and tingling, particularly in the hands and feet). R3's Annual Minimum Data Set (MDS) dated 10/16/24 documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R3 used a wheelchair to assist with mobility. R3 required supervision to partial/moderate assistance from staff for her activities of daily living (ADL). R3 had a urinary ostomy (surgical opening from an area inside the body to the outside) and was always continent of bowel. R3's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/21/24 documented she was at risk for alteration of her functional abilities and complications from decreased mobility related to her current diagnoses. R3 had an 11-day hospitalization. R3 currently required one staff and partial/moderate assist for toilet hygiene, bathing, upper and lower body dressing, and transfers from bed to chair. R3 utilized a manual wheelchair for mobility. R3's Care Plan last revised on 04/04/25 directed staff to administer medication as ordered for neuropathy; observe for adverse effects and report to the physician as needed. R3's Care Plan lacked staff direction on self-administration of her physician-ordered Voltaren. R3's Order Summary Report in the EMR documented a physician's order dated 12/30/24 for Voltaren external gel one percent (1%) to apply topically to the affected joints every six hours (6) hours as needed for pain. Use two (2) grams (gm) of unsupervised self-administration. May leave medication at the bedside. R3's Assessments tab of the EMR lacked an assessment for Self-Administration of Medications. On 06/25/25 at 10:06 AM, R3 stated she has had her Voltaren gel in her room since it had been ordered, and she applied it herself when she needed to. R3 stated she had never been assessed to self-administer the medication that she could recall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that any resident should be assessed to be safe to self-administer medication. LN G stated she would expect the care plan to be updated to reflect that R3 could self-administer or apply her Voltaren. On 06/26/25 at 02:06 PM, Administrative Nurse E stated that R3's care plan should have been revised to let staff know if she was safe to self-administer her Voltaren. The facility lacked a policy for care plan revision.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. - R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and need for assistance with personal hygiene. The Significant Change Minimum Data Set (MDS) dated 08/07/24 documented R12 moderately impaired cognition. The MDS documented R12 had an indwelling catheter. The MDS documented R12 was dependent on staff assistance for toileting and bathing. The MDS documented R12 had one non-injury fall during the observation period. The Quarterly MDS dated 05/06/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented that R12 had a limited range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension) of her upper extremities. The MDS documented R12 was dependent on staff assistance for toileting and bathing. The MDS documented R12 had one non-injury fall during the observation period. R12's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 08/13/24, lacked analysis. The facility was able to provide the documentation after the survey. R12's Care Plan, dated 09/03/24, documented she was dependent on staff assistance for bathing. R12's EMR under the Reports tab and Bathing task was reviewed for the following dates: 02/11/25 to 06/20/25 (120 days). The EMR documented 10 Shower (SH) on 02/04/25, 02/07/25, 02/18/25, 04/18/25, 05/02/25, 05/13/25, 05/20/25, 05/27/25, 05/30/25, and 06/06/25, two Sponge Bath were documented on 02/21/25 and 05/16/25, one Resident Refused (RR) on 05/06/25, and 21 Not Applicable (NA) were documented on 02/11/25, 02/14/25, 02/25/25, 02/28/25, 03/04/25, 03/07/25, 03/11/25, 03/14/25, 03/18/25, 03/28/25, 04/01/25, 04/04/25, 04/08/25, 04/11/25, 04/15/25, 04/22/25, 04/29/25, 05/09/25, 05/23/25, 06/03/25, and 06/10/25. R12's clinical record lacked evidence that she was unavailable for care during the 120 days reviewed. R12's notes lacked documentation regarding bathing refusals or attempts to offer alternatives. On 06/25/25 at 07:18 AM, R12 laid asleep on her bed, her call bell was out of her reach. The call bell was provided by the facility due to the facility's call light had stopped functioning on 04/21/25. R was on the bedside table. R12's bedside table was outside her reach. R12's soft call light with the bright colored tape was not present. On 06/26/25 at 12:38 PM, Licensed Nurse (LN) G stated that each resident had assigned days for bathing at least two times a week. LN G stated that if a resident were to refuse their bath, the staff would reapproach again to offer them bathing options. LN G stated that if the resident refused the bath/shower, it would be documented in their EMR. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 01:09 PM, Certified Nurse Aide (CNA) M stated each resident was offered at least two baths each week. CNA M stated that if a resident were to refuse their bath, the staff would return later and offer again. CNA M stated the refusal would be documented in the resident's EMR under tasks. On 06/26/25 at 02:50 PM, Administrative Nurse D stated that each resident was able to choose the day and type of bath. Administrative Nurse D stated she runs the bathing report to ensure each resident was provided a bath. The facility's Activities of Daily Living (ADL) policy, last revised 01/2025, documented a resident's abilities in ADLs do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This included the president's ability to bathe, dress, groom, transfer, ambulate, toilet, eat, and use speech, language, or other functional communication systems. Nursing assistants would provide assistance with ADLs based on the resident's individualized plan of care. The facility identified a census of 58 residents. The sample included 14 residents, with 14 reviewed for activities of daily living (ADL). Based on observation, record review, and interviews, the facility failed to provide Residents (R) 21 and R12 with consistent bathing opportunities. This deficient practice placed both residents at risk for impaired psycho-social well-being and skin breakdown. Findings Included: - The Medical Diagnosis section within R21's Electronic Medical Records (EMR) included diagnoses of end-stage renal disease, absence of left leg, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and need for assistance with personal care. R21's Quarterly Minimum Data Set (MDS) completed 03/07/25 noted a Brief Interview for Mental Status (BIMS) score of 13, indicating mild cognitive impairment. The MDS noted bilateral upper and lower extremity impairments, and she used a wheelchair for mobility. The MDS noted she was dependent on staff assistance for bathing, toileting, dressing, personal hygiene, and bed mobility. The MDS noted she had frequent bowel and bladder incontinence. R21's Functional Abilities Care Area Assessment (CAA) completed 12/09/24 indicated she required extensive assistance from staff to complete her activities of daily living. The CAA noted she used a wheelchair for mobility and a Hoyer lift (full-body mechanical lift) for transfers. The CAA noted she was incontinent of bowel and bladder and required assistance with toileting, peri-care, and clothing management. R21's Care Plan initiated on 09/05/24 indicated she was at risk for ADL deficit due to her medical diagnoses. The plan noted she was dependent on staff assistance for bathing, toileting, transfers, dressing, wheelchair ambulation, and bed mobility. The plan noted she had urinary incontinence and was at risk for skin breakdown and infections. The plan instructed staff to inspect her skin during bathing and daily care. The MDS noted she was at risk for skin breakdown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R21's EMR under Documentation Survey Report from 06/01/25 through 06/26/25 (26 days reviewed). The report indicated she preferred to have a bath twice weekly (Sundays and Thursdays). The report indicated she received bathing on 06/01/25, 06/05/25, 06/12/25, and 06/19/25. The report indicated she did not receive her scheduled Sunday bath or 2nd weekly bath for the week of 6/8, 6/15, and 6/22. R21's EMR indicated no rationale or refusals for the missing bathing occurrences. On 06/24/25 at 09:30 AM, R21 sat in her wheelchair in her room. R21's hair was greasy and uncombed. R21's fingernails were dirty and untrimmed. She stated was upset because the facility was not properly bathing her. She stated she had not received her Sunday bath in the last three weeks and was made to wait until Thursday. She stated the facility did not have enough staff on Sundays to complete bathing. On 06/26/25 at 12:38 PM, License Nurse (LN) G stated staff were required to sign off on Sundays; she stated staff must make three attempts before accepting the refusal. She stated refusals were marked in the EMR. She stated that the missing bathing would be offered on the next shift or the next day. On 06/26/25 at 01:30 PM, Certified Nurse's Aide (CNA) M stated R21 often refused staff assistance, but it should have been marked in the EMR as offered. She stated that direct care staff were expected to provide three attempts before telling the nurse. She stated the nurse would then talk to the resident. She stated that staff would provide the resident with a bath upon request. On 06/26/25 at 02:11 PM, Administrative Nurse D stated staff were expected to provide the residents' bathing based upon the residents' preference and scheduled days. She stated staff were expected to make multiple attempts at bathing and reschedule bathing for the next shift or day if missed. The facility's Activities of Daily Living (ADL) policy, last reviewed 09/2024, indicated all residents would be provided ADL assistance and consistent bathing opportunities for all residents. The policy noted residents would be assessed for their specific care needs and provided interventions.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to provide direct, interactive activities based on resident preferences for the residents on weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. Findings Included: - A review of the facility's Activity Calendars for March 2024, April 2025, May 2025, and June 2025 was completed. A review of Sunday for the majority of each month revealed the residents were only offered a self-led activity packet for an activity. On 06/25/24 at 02:00 PM, the facility's Resident Council reported that the weekend activities were inconsistent with what was scheduled. The council reported on Sunday's the residents did not always receive staff-led activities. The council stated they were often offered puzzles or packets to complete individually. The council reported that the facility was often short-staffed on Sundays. They stated the activities staff did not work on Sundays, and staff were often too busy to complete activity groups. On 06/26/25 at 12:38 PM, Activities Staff Z stated the facility had a staff member to come in on weekends and complete activities. She stated the facility provided shopping trips and had volunteers come in on Saturdays. She stated the facility was to have staff-led activities each day of the week. She stated the facility also provides activity packets for the residents. On 06/26/25 at 01:30 PM, Certified Nurse's Aide (CNA) M stated that activities staff often came in on Saturdays to complete the groups. She stated the facility provided a packet with puzzles, games, coloring pages, and drawings for residents to complete on Sundays. The facility's Activities Programming policy, revised 05/2025, indicated the facility would provide activities that meet the residents' needs and interests to support their physical, mental, and psychosocial well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. The facility identified a census of 58 residents. The sample included 14 residents, with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician's order for weights to monitor for edema and fluid overload for Resident (R) 52. This deficient practice placed R52 at risk for delay in treatment related to fluid overload and untreated illness. Findings included: - R52's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), hypotension (low blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), muscle weakness, unsteady on her feet, and the need for assistance with personal care. The admission Minimum Data Set (MDS) dated 07/12/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R52 had received antidepressant (a class of medications used to treat mood disorders) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and hypnotic (a class of medications used to induce sleep) medication during the observation period. The Quarterly MDS dated 03/24/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R52 had received diuretic medication, antidepressant medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. R52's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/17/24 lacked analysis. The facility was able to provide the documentation after the survey. R52's Care Plan, with a revision date of 11/05/24, documented the nursing staff would administer medications as ordered. The plan of care documented nursing staff would observe for adverse effects and report to the physician as needed. R52's EMR under the Orders tab revealed the following physician orders: Spironolactone (diuretic) oral tablet 50 milligrams (mg), give one tablet by mouth in the morning for edema dated 01/29/25. Weigh in the morning every Monday and Thursday for fluid overload. Call the physician if a weight of greater than (>) five pounds in a week for four weeks, dated 06/05/25. Furosemide (diuretic) oral tablet 20mg (Lasix), give two tablets (40mg) by mouth in the morning for Fluid overload, dated 06/05/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R52's EMR, Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 06/05/25 to 06/24/25 lacked evidence weights were obtained as ordered by the physician. Under the Vital Sign tab revealed a weight recorded on 06/23/25 of 152.6 pounds. R52's clinical record lacked evidence the physician was notified of the lack of weights. On 06/25/25 at 07:19 AM, R52 laid on her bed, and she sat up on the side of her bed. R52's room still had a urine odor in the room. On 06/26/25 at 02:50 PM, Administrative Nurse D stated she would expect the physician's order to be followed, and the medication was administered as ordered. Administrative Nurse D stated that the physician should be notified of the lack of weight monitoring for edema and fluid overload. The facility's Pharmacy Services/Nursing Services policy last revised 01/2025 documented it was the policy of the facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the president's plan of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. The facility identified a census of 58 residents. The sample included 14 residents, with three residents reviewed for treatment/services to prevent/heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure-reducing measures were placed on Resident (R)13. This placed R13 at increased risk for pressure ulcer development. Findings Included: - R13's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of malnutrition, epilepsy (brain disorder characterized by repeated seizures), adult failure to thrive, cognitive communication deficit (difficulties with communication that arise from impairments in cognitive processes like attention, memory and executive functions), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), encounter for palliative care, dysphagia (swallowing difficulty), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R13's Significant Change Minimum Data Set (MDS) dated 06/03/25 documented a Brief Interview of Mental Status (BIMS) of nine, which indicated moderately impaired cognition. The MDS documented R13 needed assistance from staff for all activities of daily living (ADL). The MDS documented R13 was at risk of developing pressure ulcers. R13's Pressure Ulcer/ Injury Care Area Assessment (CAA) dated 06/03/25 documented R13 was at risk for alteration in skin integrity related to cerebral infarction, adult failure to thrive, and epilepsy. The CAA documented she was admitted to hospice services. The CAA documented R13 had a poor appetite and was incontinent of bowel and bladder. The CAA documented R13 wished to remain in bed most of the time and requires staff to turn and reposition approximately every two hours, and as needed. R13's Care Plan dated 01/31/25 documented a pressure ulcer or was potentially for pressure ulcer development of the right great toe related to decreased mobility, and malnutrition. R13's plan of care documented R13 had a deep tissue injury to the left great toe to heal without complications. The plan of care documented that staff would treat R13's deep tissue injury per physicians' orders, and staff were to apply heel protectors when in bed as a preventative measure. R13's Braden Scale for Prediction Pressure Sore Risk dated 04/30/25 documented a score of 11, indicating a high risk for pressure ulcers. R13's physician's orders under the Orders tab revealed the following orders: Heel protectors bilateral when in bed as a preventive measure every shift for pressure dated 02/26/25. On 06/24/25 at 08:25 AM, R13 laid on her bed, covered with a blue blanket. R13's boots were in her Broda chair, R13 did not have boots on her heels, and her heels laid directly on the mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/25 at 02:30 PM, R13 laid in her bed, R13's boots were in her Broda chair. R13 did not have boots on her heels, and her heels her heels laid directly on the mattress. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that all nursing staff have access to the care plan. LNG stated it was the CAN's duty to apply boots when the resident was placed in bed. LN G stated it was the nurse on duty to round and ensure the boots were applied to the residents' heels. On 06/26/25 at 01:17 PM, Certified Nurse's Aide (CNA) M stated she had access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA M stated she could not see the full care plan, but could see what interventions needed to be done each shift for her residents. On 06/26/25 at 02:04 PM, Administrative Nurse D stated that if the residents' boots applied to heels were an order, the order would show on the Treatment Administrative Record (TAR). Administrative Nurse D stated the CNAs have access to the Kardex and Task, and the information should be seen in both places. The facility's Pressure Ulcer Prevention policy, reviewed on 01/25, documented skin inspections/assessments would be completed on admission for all facility residents. The risk for pressure ulcer development would be evaluated on admission and at other pertinent periods of admission for all residents using the Braden Scale for pressure ulcer risk. Residents and families were to be encouraged to participate to the extent possible in the care and prevention of skin breakdown. Any resident with a Braden score of 12 or less should have interventions initiated based on the risks identified to protect and promote skin integrity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. - R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and need for assistance with personal hygiene. The Significant Change Minimum Data Set (MDS) dated 08/07/24 documented R12 moderately impaired cognition. The MDS documented R12 had an indwelling catheter. The MDS documented R12 was dependent on staff assistance for toileting and bathing. The MDS documented R12 had one non-injury fall during the observation period. The Quarterly MDS dated 05/06/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented that R12 had a limited range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension) of her upper extremities. The MDS documented R12 was dependent on staff assistance for toileting and bathing. The MDS documented R12 had one non-injury fall during the observation period. R12's Falls Care Area Assessment (CAA) dated 08/13/24 lacked analysis. The facility was able to provide the documentation after the survey. R12's Care Plan, dated 09/03/24, documented R12 required two staff members to assist with transfers with the use of a Hoyer (total body mechanical lift) lift. The plan of care documented that the nursing staff would keep R12's needed items within her reach. The plan of care dated 05/20/25 documented a fall from bed on 05/18/25 at midnight. The intervention was R12 was given a soft call light with a bright colored tape. The facility's call light system had stopped working on 04/21/25. R12's EMR under the Progress Notes tab revealed the following: Interdisciplinary Team (IDT) note dated 01/16/25 at 01:51 PM was to review R12's fall on 01/15/25. R12 attempted to transfer herself from her bed. The intervention was to request a bolster (mattress with raised edges) overlay for R12's mattress. On 03/11/25 at 12:36 PM, a Fall Committee IDT note documented R12 was found on the floor in the activity room. The root cause of the unwitnessed fall was R12 had slid out of her chair. Intervention was the Consultant Pharmacist would complete a medication review, and therapy would elevate her wheelchair. On 05/20/25 at 10:41 AM, a Fall Committee IDT note documented the IDT had met to review R12's fall on 05/15/25, which was an unwitnessed fall. Staff documented R12 was unable to remember to use her call light, and the fall intervention would be to replace R12's call light with a soft-touch call. The facility's call light system had stopped functioning on 04/21/25. On 05/27/25 at 11:08 AM, a Fall Committee IDT note documented the IDT had met to review R12's unwitnessed fall on 05/27/25 at midnight. R12 was found on the floor mat beside her bed. The root cause analysis was that R12 had slid out of her bed onto the floor. Intervention was to request a bariatric (associated with obesity) bed for R12. (continued on next page)

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	175187	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Health and Wellness	6501 W 75th Street Overland Park, KS 66204

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's EMR under the Assessments tab revealed the following LN-Fall Risk Evaluation dated 05/27/25, documented she was a high fall risk. On 06/25/25 at 07:18 AM, R12 laid asleep on her bed, her call bell was out of her reach. The call bell was provided by the facility due to the facility's call light had stopped functioning on 04/21/25. R was on the bedside table. R12's bedside table was outside her reach. R12's soft call light with the bright colored tape was not present. On 06/26/25 at 07:20 AM, R12 was asleep on her bed, and the call bell provided by the facility was on the bedside table outside R12's reach. On 06/26/25 at 12:38 PM, Licensed Nurse (LN) G stated staff would find R12 on the floor. LN G stated the nurse should place a new fall intervention on the resident's care plan to help prevent further falls and possible injuries. LN G stated that the fall interventions could be found on the resident's care plan and the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). LN G stated the nurse was responsible for ensuring the resident's fall interventions are in place, and everyone's responsibility to ensure the call bells are within their reach. On 06/26/25 at 01:09 PM, Certified Nurse Aide (CNA) M stated she had access to the Kardex but not the resident's care plan. CNA M stated it was everyone's responsibility to ensure call bells are within the resident's reach and fall interventions are in place. On 06/26/25 at 02:50 PM, Administrative Nurse D stated everyone was responsible for ensuring the resident's call bells are within the resident's reach. Administrative Nurse D stated everyone was also responsible for ensuring the resident's fall interventions were in place to prevent further falls and possible injuries. The facility's Fall Management System policy, last reviewed/revised 04/2025, documented it was the policy of the facility to provide an environment that remains as free of accident hazards as possible. It was also the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The facility had a census of 58 residents. The sample included 14 residents, with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure electrical panels and cleaning chemicals in a safe, locked area, and out of reach of the ten cognitively impaired, independently mobile residents. The facility additionally failed to ensure Residents (R) 59, R49, and R12's preventative fall interventions were being followed. This placed the affected residents at risk for preventable accidents and injuries. Findings Included: - On 06/24/25 at 08:03 AM, an inspection of the central hallway revealed an unsecured room entry door was left propped open. The door was labeled Staff Only. An inspection of the room revealed five unlocked electrical panels on the wall. An inspection of the panel revealed the warning high voltage -the danger of electric shock on the inside of the panel. On 06/24/25 at 08:30 AM, Certified Nurse Aide (CNA) M closed the door and stated the room was an area staff could use. She stated residents were not allowed in the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/26/25 at 02:11 PM, Administrative Nurse D stated the central closet should be locked at all times. She stated the residents should not have access to areas with potential hazards. A review of the facility's Home-like Environment policy, revised 02/2025, indicated the facility was to ensure a safe, clean, and comfortable environment for the residents. - The Medical Diagnosis section within R59's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and need for assistance with personal cares. R59's Quarterly Minimum Data Set (MDS) completed 03/19/25 noted a Brief Interview for Mental Status (BIMS) score of eight, indicating mild cognitive impairment. The MDS noted no upper or lower extremity impairments. The MDS noted he used a walker for mobility. The MDS noted he was independent with bathing, toileting, mobility, and dressing. The MDS noted he was frequently incontinent of bowel and bladder, but had no toileting program in place. The MDS noted he rejected care from staff for four to six days during the review. R59's Functional Abilities Care Area Assessments (CAA) completed on 12/31/24 indicated he began hospice services. The CAA noted he required verbal cues and redirection to complete his activities of daily living (ADL). The CAA noted he had confusion at times and would urinate in cups in his room. R59's Care Plan initiated on 03/04/20 indicated she was at risk for ADL deficit due to her medical diagnosis. The plan indicated he could independently complete walking, bathing, transferring, dressing, and toileting. The plan indicated he was at risk for both communication issues and falls related to his medical diagnosis. The plan instructed staff to ensure his call light remained within his reach and for staff to encourage its use. On 06/24/25 at 07:05 AM, R59 slept in his bed. R59's call light was pushed up underneath the front of his mattress between the mattress and the bed springs. The call light was out of his reach. At 10:22 AM, R59's call light remained underneath his mattress and out of his reach. On 06/25/25 at 01:30 PM, R59 rested in his bed. His call light remained stuffed underneath his mattress and out of his reach. On 06/26/25 at 01:30 PM, Certified Nurse's Aide (CNA) M stated that the call lights or call bells were to remain within the reach of each resident. She stated staff were expected to reposition the devices each time they entered to room to ensure they remained accessible to the residents. On 06/26/25 at 02:11 PM, Administrative Nurse D stated the call devices were to be within the resident's reach at all times. She stated that staff were to ensure the resident could reach the lights and operate them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Prevention policy, revised 01/2025, stated the facility was to assess the risks related to each resident based upon their comprehensive assessment and follow the implemented interventions to minimize the risks.- R49's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hyperlipidemia (condition of elevated blood lipid levels), hypertension (high blood pressure), osteomyelitis (local or generalized infection of the bone and bone marrow) of sacral, pressure ulcer of sacral area Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone), schizoaffective disorder (a mental health condition characterized by a combination of symptoms from schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought)) and a mood disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), reduced mobility, contracture (abnormal permanent fixation of a joint or muscle), muscle weakness, need for assistance with personal care, repeated falls, and communication deficit (difficulties with communication that arise from impairments in cognitive difficulties with communication that arise from impairments in cognitive processes). The Quarterly Minimum Data Set (MDS) for R49 dated 05/23/25 recorded a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS recorded R49 had falls since admission. The MDS documented R49 had two non-injury falls and one fall with injury during the observation period. R49's Falls Care Assessment (CAA) dated 11/24/24 documented R49 used a wheelchair for mobility propelled by staff. The CAA documented R49 used a Hoyer (total body mechanical lift) for transfers. The CAA documented R49 was incontinent of bowel and bladder and needed staff assistance. The CAA documented R49 had no new falls since the last assessment. R49's Care Plan dated 01/06/25 documented R49 was at risk for falls related to osteomyelitis (local or generalized infection of the bone and bone marrow). The plan of care for R49 dated 03/25/25 documented R49 had a fall in his bedroom from his wheelchair. The intervention was staff would offer to lay him down or reposition him. The plan of care for R49 dated 04/02/25, documented R49 had a fall from his bed, and the intervention would be to place a fall mat next to his bed on the left side and ensure the bed was in a low position. R49's plan of care dated 04/30/25 documented R49 had a fall in his bedroom, and the intervention was staff to ensure R49's call light was within his reach. On 06/24/25 at 07:35 PM, R49 laid on his bed. R49's blue fall mat was folded up at the end of the empty bed in his room. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that all staff have access to the care plan. LN G stated that all falls have an intervention put in place with each fall. LN G stated nursing communicates with the Certified Nursing Aides (CNA) to ensure they were aware of the interventions put in place. LN G stated that all nursing staff were responsible for ensuring the interventions were always in place. On 06/26/25 at 01:28 PM, CNA M stated she did not have full access to the care plan. CNA M stated she did have access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA M stated that if there was an intervention for a fall, she would be able to see what the intervention was in the Kardex and in Tasks. CNA M stated that the nurses also communicated with the CNAs to ensure all interventions were put in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/26/25 at 02:04 PM, Administrative Nurse D stated CNAs have access to the Kardex and Tasks. She stated that if the nurse checks the box, the interventions pull over to the Kardex. Administrative Nurse D stated that the LN has access to the full care plan. She stated it was everyone's responsibility to ensure fall prevention and interventions were put in place. The facility's Fall Management System policy, last reviewed/revised 04/2025, documented it was the policy of the facility to provide an environment that remains as free of accident hazards as possible. It was also the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and need for assistance with personal hygiene. The Significant Change Minimum Data Set (MDS) dated 08/07/24 documented R12 moderately impaired cognition. The MDS documented R12 had an indwelling catheter. The MDS documented R12 was dependent on staff assistance for toileting and bathing. The MDS documented R12 had one non-injury fall during the observation period. The Quarterly MDS dated 05/06/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented that R12 had a limited range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension) of her upper extremities. The MDS documented R12 was dependent on staff assistance for toileting and bathing. The MDS documented R12 had one non-injury fall during the observation period. R12's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 08/13/24, lacked analysis. The facility was unable to provide the documentation upon request. R12's Care Plan, dated 09/03/24, documented the nursing staff would secure R12's catheter to facilitate the flow of urine to prevent kinking of the tubing. The plan of care documented the nursing staff would position R12's catheter bag and tubing below the level of her bladder and away from the entrance of the door to her room. R12's EMR under the Orders tab revealed the following physician orders: Indwelling catheter size 18 French with a 30 cubic centimeter (cc) bulb for diagnosis of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) dated 12/05/24. On 06/24/25 at 07:40 AM, R12 was asleep on the bed with her lower extremities off to the left side of the bed. R12's indwelling urinary catheter drainage bag with dark amber urine laid directly on the floor facing the entrance door to the room. R12's call bell was on the bedside table, which was out of her reach. On 06/26/25 at 12:38 PM, Licensed Nurse (LN) G stated R12's urinary catheter drainage bag should be placed below the level of R12's bladder and never be placed on the floor. On 06/26/25 at 01:09 PM, Certified Nurse Aide (CNA) M stated R12's catheter drainage bag should always be kept below R12's bladder. CNA M stated the drainage bag should be in a privacy bag and placed on the frame of the bed. CNA M stated the drainage bag should never be placed on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/26/25 at 02:50 PM, Administrative Nurse D stated she expected a catheter drainage bag to be placed in a privacy bag, kept below the level of the resident's bladder, and never be placed on the floor. The facility's Indwelling Urinary Catheter Care policy, last revised 03/2025, documented it was the policy of the facility that each resident with an indwelling catheter would receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. - R52's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), hypotension (low blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), muscle weakness, unsteady on her feet, and the need for assistance with personal care. The admission Minimum Data Set (MDS) dated 07/12/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R52 had received antidepressant (a class of medications used to treat mood disorders) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and hypnotic (a class of medications used to induce sleep) medication during the observation period. The MDS documented R52 required partial to moderate staff assistance with toileting. The MDS also documented R52 required supervision to hand touch staff assistance with personal hygiene. The MDS documented R52 was occasionally incontinent of urine and was not on a toileting program. The Quarterly MDS dated 03/24/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R52 had received diuretic medication, antidepressant medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The MDS documented R52 was independent with toileting and personal hygiene. The MDS documented R52 was occasionally incontinent of urine and was not on a toileting program. R52's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 07/17/24, lacked analysis. The facility was able to provide the analysis documentation after the survey. R52's Care Plan, dated 09/15/24, documented she was to wear disposable briefs, and staff would change her every two hours and as needed. The plan of care documented staff would check her as required for incontinence and provide peri-care assistance. The plan of care dated 06/23/25 documented R52 required partial to moderate assistance with toileting hygiene. R52's EMR under the Assessment tab revealed the following LN-Bowel and Bladder Evaluation dated 05/13/25, which indicated R52 was a possible candidate for a Bowel and Bladder re-training. R52's EMR lacked documentation, and the toileting program was attempted. On 06/24/25 at 07:40 AM, R52 was at breakfast. R52's room had a strong urine odor noted from her bed and floor. On 06/25/25 at 07:19 AM, R52 laid on her bed, and she sat up on the side of her bed. R52's room still had a urine odor in the room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/26/25 at 12:38 PM, Licensed Nurse (LN) G stated she would fill out the LN-Bowel and Bladder Evaluation at times. LN G stated if the assessment indicated the resident was a good candidate for a toileting program, she would let the assisted director of nursing or Administrative Nurse D know the assessment results. LN G stated R52 never refused assistance when staff offered. On 06/26/25 at 01:09 PM, Certified Nurse Aide (CNA) M stated R52 was independent with everything. CNA M stated R52 never asked for any assistance. On 06/26/25 at 02:50 PM, Administrative Nurse D stated each resident was assessed at the time of admission, quarterly, or with any changes. Administrative Nurse D stated that if a resident was a good candidate for a toileting program, the interdisciplinary team (IDT) and therapy would evaluate and determine a plan for that resident. The facility did not provide a policy related to toileting programs.- R10's Electronic Medical Record (EMR) documented the following diagnoses hypertension (HTN - elevated blood pressure), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), atrial flutter (a type of abnormal heart rhythm where the heart's upper chambers beat too quickly and regularly), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), seizures (violent involuntary series of contractions of a group of muscles), and neuromuscular dysfunction of the bladder (a condition where the nerves and muscles that control the bladder don't work together properly, leading to issues with urine storage and emptying). R10's Annual Minimum Data Set (MDS) dated 04/04/25 documented he had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R10 had impairment of both upper and lower extremities on one side. R10 required a wheelchair to assist with mobility. R10 required substantial/maximal staff assistance with his functional abilities for his activities of daily living (ADL). R10 was dependent on staff for toileting and bathing. R10 required an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). R10's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 04/15/25 documented he was at risk of complications of having an indwelling catheter and incontinence of bowel. R10's diagnoses include a CVA with right-sided hemiplegia/hemiparesis, aphasia, neuromuscular dysfunction of the bladder requiring a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag), contracture of the right hand, atrial flutter, DM, and seizures. This places R10 at risk of further skin breakdown. R10's Care Plan, last revised on 03/07/25, directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance of the room door. The Care Plan directed staff to monitor, record, and report to the physician for signs and symptoms of a urinary tract infection (UTI-an infection in any part of the urinary system). The Care Plan directed staff that R10 had an indwelling catheter as ordered. R10's Order Summary Report documented an order dated 09/15/24 to document output every shift. A review of R10's March 2025Treatment Administration Record (TAR) in the EMR revealed R10's urinary catheter output was not documented on four of 62 opportunities. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R10's April 2025 TAR in the EMR revealed R10's urinary catheter output was not documented on six of 60 opportunities. A review of R10's May 2025 TAR in the EMR revealed R10's urinary catheter output was not documented on eight of 62 opportunities. A review of R10's June 2025 TAR in the EMR revealed R10's urinary catheter output was not documented on five of 50 opportunities. On 06/25/25 at 07:46 AM, R10 was propelled by staff in his wheelchair to the dining room. R10 had his feet on the foot on pedals. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that the certified nurse aides (CNA) were responsible for emptying the catheter bag at the end of each shift. LN G stated that CNA's were to report to the nurse what the output amount was and if any irregular color or smell was noted. LN G stated the nurse was responsible for ensuring that the output amount was documented, and a progress note would be charted if any irregularity had been noted. LN G stated that the physician should be notified of any irregularities or changes in the urine. LN G stated R10 had a history of frequent UTIs. On 06/26/25 at 02:40 PM, Administrative Nurse D stated that anyone who had a catheter should have the output documented by the nurses. Administrative Nurse D stated the CNA was responsible for emptying the catheter bag at the end of the shift and reporting the amount and any irregularities to the nurse. The facility lacked a policy regarding residents with a catheter and or UTI prevention.- The Medical Diagnosis section within R35's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and need for assistance with personal cares. R35's Quarterly Minimum Data Set (MDS) completed 04/04/25 noted a Brief Interview for Mental Status (BIMS) score of eleven, indicating mild cognitive impairment. The MDS noted no upper or lower extremity impairments. The MDS noted he used a wheelchair for mobility. The MDS noted he required partial to moderate assistance from staff for bathing, toileting, and dressing. The MDS noted he was frequently incontinent of bowel and bladder, but had no toileting program in place. The MDS noted he rejected care from staff for four to six days during the review. R35's Behavioral, Functional Abilities, and Urinary Incontinence Care Area Assessments (CAA) were not completed or available for review. R35's Care Plan initiated on 09/03/24 indicated he was at risk for his activities of daily living (ADLs) deficit due to her medical diagnoses. The plan indicated he required supervision to partial assistance for bathing, bed mobility, personal hygiene, transfer, toileting, and bathing. The plan noted he had bowel and bladder incontinence. The plan instructed staff to administer his medication as ordered for bowel regulation, provide disposable briefs, and check him for incontinence as required. The plan lacked interventions to prevent incontinence episodes or to determine if toileting interventions were attempted. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35's EMR under Assessments revealed a Bowel and Bladder Evaluation completed on 05/01/25. The evaluation revealed R35 was a possible candidate for bowel and bladder retraining. On 06/25/25 at 07:08 AM, R35 slept in his bed. R35's room smelled heavily of urine. An inspection of the floor around his bed revealed urine residue on the floor. The floor was sticky. On 06/26/25 at 08:11 AM, an inspection of R35's room revealed his floor was sticky around his bed. His room smelled heavily of urine, and the bed sheet was wet with urine. On 06/26/25 at 12:38 PM, License Nurse (LN) G stated R35 had urinary incontinence and used briefs. She was not sure if he had an individualized toileting program. She stated his room often smelled heavily of urine. She stated residents were screened for incontinence upon admission and provided toileting interventions if they were deemed a candidate. On 06/26/25 at 02:11 PM, Administrative Nurse E stated R35 had urinary incontinence and would often urinate on the floor. He stated he was moved to a different room and could not have a roommate due to his incontinence issues. He stated all residents were screened upon admission and provided interventions. The facility's Bowel and Bladder Incontinence policy, revised 03/2025, indicated the facility was to screen all residents at risk for bowel and bladder incontinence and provide interventions that minimize the risks related to the development of infections, skin breakdown, and urinary tract infections (UTI). The facility identified a census of 58 residents. The sample included 14 residents, with four residents observed for bowel and bladder function. Based on observation, record reviews, and interviews the facility failed to ensure Resident (R) 4 had a 22 French Foley catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) available for insertion for his suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder), the facility further failed to ensure R 12's catheter bag was not placed on the floor. The facility further failed to ensure the monitoring of R10's output was documented in his Electronic Medical Record (EMR), and further failed to establish a toileting program for R52 and R35. This deficient practice placed R4, R12, R10, R35, and R52 at risk of catheter-related complications and further urinary tract infections. Finding included: - R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (high blood), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), 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), muscle weakness, lack of coordination, reduced mobility, cognitive communication deficit, absence of right leg below the knee, absence of left leg above the knee, chronic pain, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). (continued on next page)

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Aspen Health and Wellness	6501 W 75th Street Overland Park, KS 66204

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R4 needed set up or cleanup for eating, partial/moderated assistance from staff for toileting, and was dependent on staff for bathing. The MDS documented R4 had an indwelling catheter or suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder). R4's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 06/07/24 lacked analysis. R4's Care Plan dated 10/10/24 documented R4 had a suprapubic catheter related to neurogenic dysfunction of the bladder. R4's plan of care documented R4 would be free from catheter-related trauma. R4's plan of care dated 04/24/25, the staff were to position the catheter tubing below the level of the bladder, and away from the entrance door. The plan of care for R4 directed staff to change the catheter bag and tubing as ordered using 22-Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) with 20 milliliters (ml), and provide catheter care every shift. R4's EMR under the Orders tab revealed the following physician orders: Urinary catheter anchors every shift dated 03/19/25. Urinary catheter site care, cleanse with soap and water every shift, dated 03/19/25. Indwelling catheter suprapubic, 22 French Foley 20ml in balloon for neurogenic bladder dated 03/19/25. R4's EMR under Nursing notes dated 6/19/25 documented R4's catheter was leaking. Order received to change catheter every 30 days as needed (PRN). Notified the supply person to order 22 French Foley catheters. On 06/25/25 at 08:10 AM, R4 laid on his bed with several white hand towels. R4 stated that the hand towels were to be put around his suprapubic catheter. R4 stated he had told nursing his supra pubic catheter was leaking. R4 stated that nursing informed her she would have to order a 22 French catheter, as the facility did not have the Foley catheters on hand. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated the facility had Foley catheters on hand. She stated Foley catheters were kept in the storage room. LN G stated that if a resident needed his catheter for a super pubic catheter change, the nurse on duty would be able to change the catheter or try other non-invasive things first. On 06/26/25 at 2:04 PM, Administrative Nurse D stated the facility always has extra Foley catheters on hand. Administrative Nurse D stated the nurse would be able to change the catheter if the catheter was leaking. The facility's Indwelling Urinary Catheter Care policy review 03/25 documented it was the policy of the facility that each resident with an indwelling catheter would receive a catheter daily and as needed to promote hygiene, comfort, and decrease the risk of infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 58 residents. The sample included 14 residents, with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 25's Bilevel positive airway pressure (noninvasive ventilation used to assist breathing) mask, nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask and nasal cannula (a medical device that delivers supplemental oxygen or other therapeutic gases to a patient through two small, flexible tubes inserted into the nostrils) was stored in a sanitary manner. This placed R25 at an increased risk for respiratory infection and complications. Findings included: - R25's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN - elevated blood pressure, obstructive sleep apnea (an open airway during typical breathing during sleep and a blocked airway), pulmonary edema (accumulation of extravascular fluid in the lung tissues), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, contracture (abnormal permanent fixation of a joint or muscle) of the right hand, muscle weakness, need for assistance with personal care, and aphasia (condition with disordered or absent language function). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R25 was dependent on staff for all activities of daily living (ADL), except eating, and needed supervising/touch assistance. The MDS documented R25 had impairment on both sides of his body. The MDS documented R25 used supplemental oxygen and a non-invasive medical ventilator. R25's Functional Abilities Care Area Assessment (CAA) dated 06/16/24 documented R25 was dependent on ADLs. The CAA documented R25 used a Broda chair (specialized wheelchair with the ability to tilt and recline) for mobility propelled by staff, and a Hoyer (total body mechanical lift) for transfers. The CAA documented R25 had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and required assistance with peri-cares and clothing management. R25's Care Plan dated 09/05/24 documented R25 had chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), obstructive sleep apnea, and would be free of any signs of respiratory infections. The plan of care documented staff would administer R25's BiPAP (type of non-invasive ventilation used to assist breathing) as ordered and monitor for any signs of respiratory insufficiency. The plan of care dated 02/05/25 documented R25 required his head of the bed to be elevated or extra pillows at night due to shortness of breath when he laid flat. The plan of care documented R25 would take off his BIPAP mask and put it on his bedside table or the floor. R25's plan of care lacked staff direction for the care of R25's BIPAP mask, nebulizer mask, and oxygen nasal tubing. R25's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BIPAP while sleeping, BIPAP settings 24/18 centimeters water pressure, backup rate 12 every night shift, dated 01/28/25. Ipratropium-Albuterol Solution 0.5-2.5 milligrams (mg) per three milliliters(ml), three ml inhale orally four times a day related to COPD, dated 01/28/25. BIPAP cleaning on Friday per directions. One time a day, every Friday, for CPAP cleaning tubing and mask with warm soapy water and air dry, dated 04/15/25. On 06/24/25 at 07:28 AM, R25 laid on his bed. R25's BIPAP mask was laid directly on the bedside table, and his nebulizer mask was laid on top of the BIPAP machine. R25's BIPAP mask and nebulizer mask were not stored in a sanitary manner. On 06/25/25 at 07:08 AM, R25 laid on his bed, with the head of the bed elevated. R25's BIPAP mask and nebulizer mask were laid on the bedside table. R25's oxygen cannula lay on the floor beside R25's bed. R25's BIPAP mask, nebulizer mask, and oxygen cannula were not stored in a sanitary manner. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that the BIPAP mask, nebulizer mask, and nasal oxygen tubing were to be stored in a dated plastic bag. LN G stated all nurses were responsible for ensuring respiratory equipment was stored per the facility protocol. On 06/26/25 at 01:25 AM, Certified Nurse's Aide (CNA)M stated that all respiratory equipment should be placed in a plastic bag. CNA M stated it was the responsibility of the CNA taking care of each resident to ensure the respiratory equipment was not in use and was stored appropriately. On 06/26/25 at 02:04 PM, Administrative Nurse D stated that all respiratory equipment not in use should be stored in a dated plastic bag. Administrative Nurse D stated that staff are educated on the appropriate way to store respiratory equipment not in use. Administrative Nurse D stated that all staff are responsible for ensuring the respiratory equipment was placed in a plastic bag when not in use. The facility's Infection Surveillance reviewed 03/25 documented a system of infection surveillance serves as a core activity of the facility's infection prevention and control program. The purpose was to identify infections and to monitor adherence to recommended infection prevention and control practices to reduce infections and prevent the spread of infections.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to ensure sufficient staffing to ensure adequate resident care and call light response. This placed the facility residents at risk for a decline and inadequate resident care being completed. Findings Included: - A review of the facility's Payroll-Based Journal (PBJ -Staffing Data Report) from 04/01/22 through 03/31/25 indicated the facility triggered for One Star Staffing for Fiscal Year (FY) 2024 Quarter Three 04/01/24-06/30/24), FY 2024 Quarter Four (07/01/24-09/30/24), FY 2025 Quarter One (10/01/24-12/31/24), and FY 2025 Quarter Two (01/01/25-03/31/25). The Resident Council Minutes for 04/14/25 noted concerns that residents were not getting their showers completed on their assigned shower days. The form noted the residents were being told: Staff were too busy to give a shower. The form's response section indicated the shower schedules were reviewed to verify preferences due to discrepancies between preferences and scheduled dates. The Resident Council Minutes for 05/12/25 noted concerns that call lights and resident care were not being completed in a timely manner. The Resident Council Minutes for 06/09/25 noted under concerns the council reported call lights were not being answered within a reasonable timeframe. The form's staff response indicated staff were educated on answering the call light within a reasonable time and to communicate with the resident if they need more time while assisting others. On 06/24/25 at 02:00 PM, the facility's Resident Council stated ongoing concerns related to call light response times and following the bathing schedules. The council reported ongoing issues related to low weekend and evening staffing. The council reported repeated concerns related to being told by staff that the facility did not have enough staff to complete care tasks. (Refer to Citation F565) On 06/24/25 at 09:30 AM, R21 sat in her wheelchair in her room. R21's hair was greasy and uncombed. R21's fingernails were dirty and untrimmed. She stated was upset because the facility was not properly bathing her. She stated she had not received her Sunday bath in the last three weeks and was made to wait until Thursday. She stated the facility did not have enough staff on Sundays to complete bathing. A review of her EMR indicated she missed her last three Sunday baths. (Refer to Citation F677) On 06/26/25 at 01:20 PM, Administrative Nurse E stated no concerns related to insufficient staffing. He stated the facility utilized agency staff to cover open shifts. He stated staff were expected to follow the care plans and provide care according to each resident's needs. On 06/26/25 at 01:30 PM, Administrative Staff A stated the facility had an ongoing issue with staff telling the residents that the facility did not have enough staff to complete care. She stated the facility had educated staff about the correct level of staff required to care for each resident. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Staffing, Sufficient and Competent Nursing policy, revised 04/2025, indicated the facility was to provide sufficient and competent staff to ensure the completion of care and services for all residents in accordance with resident care plans and the facility assessment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure the Consulting Pharmacists (CP) identified when staff administered R52's midodrine (a medication used to treat low blood pressure) outside the physician-ordered parameters. This placed R52 at risk for unnecessary medication administration and related complications. Findings included: - R52's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), hypotension (low blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), Muscle weakness, unsteady on her feet, and the need for assistance with personal care. The admission Minimum Data Set (MDS) dated 07/12/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R52 had received antidepressant (a class of medications used to treat mood disorders) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and hypnotic (a class of medications used to induce sleep) medication during the observation period. The Quarterly MDS dated 03/24/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R52 had received diuretic medication, antidepressant medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. R52's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/17/24 lacked analysis. The facility was able to provide the documentation after the survey. R52's Care Plan, with a revision date of 11/05/24, documented the nursing staff would administer medications as ordered. The plan of care documented nursing staff would observe for adverse effects and report to the physician as needed. R52's EMR under the Orders tab revealed the following physician orders: Midodrine (anti-hypotensive medication) hci tablet, five milligrams (mg), give one tablet by mouth two times a day related to hypotension. Do not give if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than (>) 140 millimeters (mm) of mercury (Hg) dated 01/30/25. Review of R52's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 05/01/25 to 06/14/25 (45 days), midodrine was given outside the physician-ordered parameters eight times on the following dates: On 05/01/25 blood pressure (BP) 144/81 mmHg. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/25 BP 143/83 mmHg. On 05/24/25 BP 144/90 mmHg. On 05/26/25 BP 144/77 mmHg. On 05/27/25 BP 149/73 mmHg. On 05/30/25 BP 143/80 mmHg. On 06/01/25 BP 148/91 mmHg. On 06/14/25 BP 150/98 mmHg. Review of the Monthly Medication Review (MMR) from September 2024 to May 2025 lacked evidence the CP identified and reported midodrine was given outside the physician-ordered parameters. On 06/25/25 at 07:19 AM, R52 laid on her bed, and she sat up on the side of her bed. R52's room still had a urine odor in the room. On 06/26/25 at 02:50 PM, Administrative Nurse D stated she would expect the physician's order to be followed, and the medication was administered as ordered. Administrative Nurse D stated she would expect the CP to identify and report the physician's order was not followed and given outside the ordered parameters. The facility was unable to provide a policy related to pharmacy responsibility for MMR.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. - R52's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), hypotension (low blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), muscle weakness, unsteady on her feet, and the need for assistance with personal care. The admission Minimum Data Set (MDS) dated 07/12/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R52 had received antidepressant (a class of medications used to treat mood disorders) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and hypnotic (a class of medications used to induce sleep) medication during the observation period. The Quarterly MDS dated 03/24/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R52 had received diuretic medication, antidepressant medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. R52's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/17/24 lacked analysis. The facility was able to provide the documentation after the survey. R52's Care Plan, with a revision date of 11/05/24, documented the nursing staff would administer medications as ordered. The plan of care documented nursing staff would observe for adverse effects and report to the physician as needed. R52's EMR under the Orders tab revealed the following physician orders: Midodrine (anti-hypotensive medication) HCl tablet, five milligrams (mg) give one tablet by mouth two times a day related to hypotension. Do not give if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than (>) 140 millimeters (mm) of mercury (Hg) dated 01/30/25. Review of R52's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 05/01/25 to 06/14/25 (45 days), midodrine was given outside the physician-ordered parameters eight times on the following dates: On 05/01/25 blood pressure (BP) 144/81 mmHg. On 05/02/25 BP 143/83 mmHg. On 05/24/25 BP 144/90 mmHg. On 05/26/25 BP 144/77 mmHg. On 05/27/25 BP 149/73 mmHg. On 05/30/25 BP 143/80 mmHg. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/01/25 BP 148/91 mmHg. On 06/14/25 BP 150/98 mmHg. On 06/25/25 at 07:19 AM, R52 laid on her bed, she sat up on the side of her bed. R52's room still had a urine odor in the room. On 06/26/25 at 02:50 PM, Administrative Nurse D stated she would expect the physician's order to be followed and the medication was administered as ordered. Administrative Nurse D stated she would expect the CP to identify and report that the physician's order was not followed and given outside the ordered parameters. The facility's Pharmacy Services/Nursing Services policy last revised 01/2025 documented it was the policy of the facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the president's plan of care. The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure staff monitored Resident (R) 10's blood pressure and pulse prior to administering his antihypertensive (a class of medication used to treat high blood pressure) medication, metoprolol. The facility failed to ensure R3 was safe for the self-application of her Voltaren gel (a topical medication used to relieve pain). The facility failed to ensure staff administered R52's midodrine (a medication used to treat low blood pressure) within the physician-ordered parameters. This place R10 and R52 at risk for unnecessary medication administration and related complications. Findings included: - R10's Electronic Medical Record (EMR) documented the following diagnoses hypertension (HTN - elevated blood pressure), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and atrial flutter (a type of abnormal heart rhythm where the heart's upper chambers beat too quickly and regularly). R10's Annual Minimum Data Set (MDS) dated 04/04/25 documented he had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R10 had impairment of both upper and lower extremities on one side. R10 required a wheelchair to assist with mobility. R10 required substantial/maximal staff assistance with his functional abilities for his activities of daily living (ADL). R10 was dependent on staff for toileting and bathing. R10 received an antiplatelet (medications that prevent platelets, a type of blood cell, from clumping together and forming blood clots) and a hypoglycemic (medications used to lower blood glucose levels in individuals with diabetes) medication on a regular basis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's Cognitive Loss Care Area Assessment (CAA) dated 04/15/25 documented he was at risk of complications of cognitive loss/dementia related to multiple current diagnoses of cerebrovascular accident (CVA - stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) with right sided hemiplegia/hemiparesis (weakness and paralysis on one side of the body), HTN, DM, aphasia (condition with disordered or absent language function), contracture (abnormal permanent fixation of a joint or muscle) of the right hand, and atrial flutter. R10's BIMS score was a seven, which indicated severe impairment. Staff were to continue to anticipate his needs and provide re-orientation as needed. R10's Care Plan, last revised on 03/07/25, directed staff to administer his antihypertensive medications as ordered and to observe for adverse effects. The Care Plan directed staff to hold medication as ordered, observe for adverse effects, and report to the physician as needed. R10's Order Summary Report in the EMR documented a physician's order dated 05/02/25 for metoprolol tartrate oral tablet 25 milligrams (mg) to be given twice daily by mouth for HTN. Hold and notify MD if the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 90 or the pulse was less than 60. A review of R10's Medication Administration Record (MAR) in the EMR for May 2025 revealed that R10's blood pressure and pulse lacked monitoring on 59 of 59 opportunities prior to the administration of his physician-ordered metoprolol. A review of R10's MAR in the EMR for June 2025 revealed that R10's blood pressure and pulse lacked monitoring on 15 of 50 opportunities prior to the administration of his physician-ordered metoprolol. A review of R10's Progress Notes in the EMR from 05/02/25 to 06/09/25 lacked any staff notes that the physician was notified of the lack of blood pressure and pulse readings prior to administration of metoprolol. On 06/25/25 at 07:46 AM, R10 was propelled by staff in his wheelchair to the dining room. R10 had his feet on the foot pedals. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that if a medication had parameters on the order, then she would expect the blood pressure and or the pulse to be taken prior to administering the medication. LN G stated she was unsure as to why R10's blood pressure and pulse had not been taken and documented in the MAR as ordered. On 06/26/25 at 02:40 PM, Administrative Nurse D stated that a physician's order that included parameters for blood pressure and pulse monitoring, she expected staff to obtain the reading and report to the nurse and physician as needed. Administrative Nurse D could not speak as to why the blood pressure and pulse reading had not been taken for R10 prior to being administered his metoprolol. Administrative Nurse D stated R10's MAR for May and June did have the slots to document the blood pressure and pulse. (continued on next page)

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Aspen Health and Wellness	6501 W 75th Street Overland Park, KS 66204

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Physician Orders, last revised in January 2025, documented that it was the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. It was the policy of this facility to accurately implement orders in addition to medication orders, only upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. - R34's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (swallowing difficulty), and aphasia (a condition with disordered or absent language function). The Annual Minimum Data Set (MDS) dated 02/12/25 documented R34 had severely impaired cognition. The MDS documented R34 had received hospice services during the observation period. The Quarterly MDS dated 05/13/25 documented R34 had severely impaired cognition. The MDS documented R34 had received hospice services during the observation period. R34's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/17/25, documented she had received hospice services for additional supportive care. R34's Care Plan, dated 09/12/24, documented the facility would work cooperatively with hospice team to ensure her spiritual, emotional, intellectual, physical, and social needs were met. R34's EMR under the Orders tab revealed the following physician orders: Admit to hospice services with the diagnosis of senile degeneration (cognitive decline associated with old age) dated 04/18/25. On 06/25/25 at 09:47 AM, R34 was asleep as she sat reclined in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the activity room. On 06/24/25 at 09:04 AM, R34's legal representative stated R34 had been discharged from hospice services in the past month. On 06/26/25 at 07:10 AM, Licensed Nurse (LN) H was unable to locate R34's hospice communication book. LN H stated she had not had to use R34's hospice communication book recently and would not know who would have R34's hospice communication book this early in the morning. LN H stated that the social services staff may be able to help locate it. On 06/26/25 at 07:20 AM, Social Services Staff X stated R34 had been discharged from hospice services on 05/20/25. Social Services Staff X stated she was not sure why there was a current order for hospice services for R34 that was still active. On 06/26/25 at 09:10 AM, Administrative Nurse F stated she had not been notified that R34 had been discharged from hospice services on 05/20/25. Administrative Nurse F stated she had heard that R34 was to be discharged from hospice services, but there was never an order written by the physician. On 06/26/25 at 02:50 PM, Administrative Nurse D stated she would expect hospice would communicate and work with the facility. Administrative Nurse D stated she would expect the hospice services to provide the discharge order. Administrative Nurse D stated she was the person responsible for ensuring there was collaboration between the hospice provider and the hospice provider. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's End of Life: Hospice and/or Palliative Care policy, last revision/review date of 01/2025, documented it was the policy of this facility to provide dignified and compassionate end-of-life care for terminally ill or dying residents. Through continuing interdisciplinary assessment, individualized plans would be developed and implemented to address prevention and relief of symptoms and the resident's physical, intellectual, emotional, social, spiritual, and practical needs. Support and reassurance for family and friends close to the resident would be an integral part of the plan. The facility identified a census of 58 residents. The sample included 14 residents, with two residents reviewed for hospice. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider for Resident (R) 13, and further failed to ensure collaboration between the nursing home and hospice services for R34. This deficient practice created a risk for missed or delayed services and impaired care for R13 and R34. Findings Included: - R13's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of malnutrition, epilepsy (brain disorder characterized by repeated seizures), adult failure to thrive, cognitive communication deficit(difficulties with communication that arise from impairments in cognitive processes like attention, memory, and executive functions, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), encounter for palliative care, dysphagia (swallowing difficulty), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R13's Significant Change Minimum Data Set (MDS) dated 06/03/25 documented a Brief Interview of Mental Status (BIMS) of nine, which indicated moderately impaired cognition. The MDS documented R13 needed assistance from staff for all activities of daily living (ADL). The MDS documented R13 received hospice services during the observation period. R13's Cognitive Loss / Dementia Care Area Assessment (CAA) dated 06/03/25 documented R13 was at risk of complications of cognitive loss/dementia related to cerebral infarction, adult failure to thrive, and epilepsy. R13 was admitted to hospice, and hospice was to provide additional support as needed. R13's Care Plan dated 05/28 documented R13 had a terminal prognosis related to malnutrition and was admitted to hospice services on 05/28/25. Staff were to adjust the provision of ADLS to compensate for the resident's changing abilities. Staff were to encourage participation to the extent the R13 wished to participate. Staff were to encourage R13 to express her feelings, and listen with non-judgmental acceptance and compassion. The plan of care for R13's documented Hospice Certified Nurse's Aide (CNA) was to provide showers with visits approximately two times weekly, and the hospice nurses would visit one to two times weekly as R13 could tolerate. The hospice social worker and Chaplain would provide visits as needed. R13's plan of care dated 06/02/25 documented hospice provider would supply incontinent supplies as needed; briefs, gloves, wipes, and medications were to come from the facility's pharmacy, even those covered by hospice. The facility would work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the hospice communication binder revealed R13 was admitted to hospice services on 05/28/25. A review of the hospice binder lacked documentation a CNA or Licensed Nurse (LN) had been to the facility for care for R13, the last documentation in R13's hospice binder documented a social worker had been to see R13 on 06/10/25. On 06/30/25 at 07:00 AM, the facility sent documentation of CNA and LN visits. The Email communication documented that the facility would put each visit in the hospice binder for R13. On 06/24/25 at 08:25 AM, R13 laid on her bed, covered with a blue blanket. On 06/25/25 at 01:17 PM, R13 laid in her bed. R13 was awake. On 06/25/25 at 02:22 PM, the hospice provider stated he was just made aware that the CNA and LN had not documented in R13's binder. He stated he would be in the facility to see R13 today and ensure the correct documentation was in R13's binder. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that hospice provided a book that was kept behind the nurse's station. LN G said the nursing staff could find what was provided and when hospice would be in the facility for each resident in the hospice book. LN G stated she would be able to look in the hospice binder to see what days the aide and nurse were in the facility to do care or bathing with the resident. On 06/26/25 at 01:28 PM, Certified Nurse's Aide (CNA) M stated the nurse on duty let the CNAs know who was on hospice. She stated that hospice aides communicate with the facility staff to ensure the facility knows what supplies they bring and when they give showers. CNA M stated she could also look in the hospice binder to see when the aide was in the facility. On 06/26/25 at 02:04 PM, Administrative Nurse D stated staff would be able to see collaboration of care in the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), or in the hospice binder located behind the nurse's station. Administrative Nurse D stated that the hospice providers communicate with the facility's nursing staff. The facility's End of Life: Hospice and/or Palliative Care policy, last revision/review date of 01/2025, documented it was the policy of this facility to provide dignified and compassionate end-of-life care for terminally ill or dying residents. Through continuing interdisciplinary assessment, individualized plans would be developed and implemented to address the prevention and relief of symptoms and the resident's physical, intellectual, emotional, social, spiritual, and practical needs. Support and reassurance for family and friends close to the resident would be an integral part of the plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility identified a census of 58 residents. The facility identified fifteen residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to ensure trash was stored and contained properly. The facility further failed to ensure that catheter bags were kept off the floor. The facility further failed to ensure that respiratory equipment, such as a BIPAP (a type of noninvasive ventilation used to assist breathing) mask, a nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask, and a nasal cannula, was stored in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Findings included: - An initial walkthrough of the facility was completed on 06/24/25 at 07:05 AM. Certified Nurse's Aide (CNA) O was dragging a large white trash bag with trash, and a large white trash bag of laundry down the hall. The laundry and trash were not contained. On 06/24/256 at 07:05 AM, R32 slept in her bed. R32's bed was in a low position. R32's urinary catheter collection bag was hung on the side of her bed. Her collection bag lay directly on the floor, filled with yellow urine. On 06/24/25 at 07:28 AM, R25 laid on his bed. R25's BIPAP mask was laid directly on the bedside table, and his nebulizer mask lay on top of the BIPAP machine. R25's BIPAP mask and nebulizer mask were not stored in a sanitary manner. On 06/24/25 at 07:40 AM, R12 was asleep on the bed with her lower extremities off to the left side of the bed. R12's indwelling urinary catheter drainage bag with dark amber urine laid directly on the floor facing the entrance door to the room. On 06/24/25 at 07:30 AM, in R59's room, a nasal cannula tubing was wrapped around the handle of portable oxygen canisters in a cylinder stand. On 06/26/25 at 12:37 PM, Licensed Nurse (LN) G stated that trash and laundry should be transported in the large barrels for trash and laundry that contain lids. LN G stated that all respiratory equipment should be placed in a dated bag. She stated that catheters should never touch the floor. On 06/26/25 at 02:04 PM, Administrative Nurse D stated there were laundry and trash containers with lids to transfer trash. Administrative Nurse D stated that respiratory equipment should be placed in a bag when not in use. She stated urinary catheter bags should not be on the floor; the urinary catheter bags could be placed in a wash basin if needed to ensure the catheter did not lay on the floor. The facility's Indwelling Urinary Catheter Care reviewed on 03/25 documented it was the policy of the facility that each resident with an indwelling catheter would receive catheter care daily and as needed to promote hygiene, comfort, and decrease the risk of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Infection Control policy, reviewed 10/24, documented the infection prevention and control program was a facility-wide effort involving all disciplines and individuals and was an integral part of the equality assurance and performance improvement program. It was the policy of the facility to provide the necessary supplies, education, and oversight to ensure healthcare workers performed hand hygiene based on accepted standards.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program, including antibiotic stewardship for the residents of the facility. Findings included: - Review of the Infection Control Log for tracking and trending infections from May 2024 through May 2025, lacked evidence of trending organism identifications in December 2024, January 2025, and February 2025. The facility was unable to provide evidence of trending upon request. A review of Resident (R) 34's Electronic Medical Record EMR documented Ciprofloxacin (antibiotic medication) HCL ophthalmic (eye) solution, installed two drops in both eyes three times a day for bacterial conjunctivitis (infection of the eye) for seven days, dated 06/01/25. A review of R12's EMR documented Ofloxacin (antibiotic) ophthalmic solution instilled two drops in both eyes four times a day for conjunctivitis/blepharitis (eye and eyelid infection) for seven days, dated 05/20/25. A review of the antibiotic surveillance binder lacked tracking and trending of eye infections for R34 and R12. On 06/25/24 at 02:04 PM, Administrative Nurse E stated that the tracking and trending were done in real-time to ensure clusters of infections were monitored and education was given to staff as needed. Administrative Nurse E stated he could not contest any months before March 2025. He stated the facility had a few infection preventionists before March. Administrative Nurse E stated the facility did do tracking for the months of March, April, and May; he stated the Administrator had those months in her binder. The facility's Infection Surveillance reviewed 03/25 documented a system of infection surveillance serves as a core activity of the facility's infection prevention and control program. The purpose was to identify infections and to monitor adherence to recommended infection prevention and control practices to reduce infections and prevent the spread of infections.