STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175205	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilson Care and Rehab	611 31st Street Wilson, KS 67490

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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 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. (continued on next page)

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility had a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to resolve recurring issues reported by the Resident Council. Findings included:- A review of the facility's Resident Council Minutes from 12/10/24 to 11/28/25 indicated the council had recurring concerns with call light response times and delivery of care. The Resident Council Minutes for 04/08/25 noted the resident's had concerns with call lights being turned off, staff leaving, and then not returning to complete their requests. In addition, the council requested that staff be quiet during activities like church and movies. The facility's response to the council's concern included that staff were provided with re-education pertaining to answering resident call lights and noted staff would show respect during activities such as church or movies at the nurse's station. The Resident Council Minutes for 05/28/25 again noted the resident call lights were being turned off by staff without completing cares, staff remaining loud during resident activities, and staff being preoccupied/complaining about being short-staffed and complaining about other coworkers. The facility response to the council after reviewing their concerns was to speak to both the day and night shift staff regarding timing of addressing call lights and reminded to ask residents for assistance expectations. The facility's department heads would assist with the council's concerns while in the building, and the facility department heads would reiterate resident concerns at all staff meetings. The Resident Council Minutes for 06/10/25 again noted residents had concerns with call light answer times and noted the staff complaints were ongoing. The facility's response to the resident concerns was to put out education sheets/reviews for staff, but to also discuss the education at an all-staff meeting. The Resident Council Minutes for 07/08/25 again reported the resident's concerns with the timely answer of call lights was not resolved, and staff attitudes were described as snotty. The facility's response to the ongoing concern was to discuss concerns and set out expectations at a mandatory staff meeting. The Resident Council Meeting for 10/16/25 again noted residents had concerns with call lights not being answered promptly. The minutes lacked a response from the facility. The Resident Council Minutes for 11/28/25 noted resident's had concerns, which they reported they felt like a burden to staff with Certified Nurse Aides (CNA) huffing, scoffing, and cussing when the resident's requested care, when answering call lights was delayed too long, and residents were told someone would return shortly to assist them, but no one returned. The facility's response to the residents was they would address their concerns and educate staff of concerns. On 12/11/25 at 08:39 AM, R28 reported the wait for staff to answer call lights was long. R28 reported staff had attitudes toward requests. R28 reported this was an ongoing problem and felt the facility did not have enough staff to care for all the residents. On 12/11/25 at 11:44 AM, Administrative Staff A reported the facility's call light system was being upgraded to track resident use and the length of call light response so the facility could better analyze the root cause of residents' concerns with staff response to call lights. On 12/11/25 at 12:55 PM, Administrative Nurse D reported she had been employed by the facility since 10/2025 and had not had a chance to address the call light concerns. The facility's Resident Council, Family Council policy, dated 08/2025, documented that the community would assign a staff member, who is approved by the council, who is responsible for providing assistance and responding to written requests of the council, and responses are presented at the next meeting or sooner, if indicated. The Quality Assurance Committee within the facility would review the data from the Resident Council as part of their quality review. Issues documented on the council responses forms may be referred to the Quality Assurance Committee.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility had a census of 34 residents. The sample included 12 residents, with three reviewed for Medicare Liability Notices. Based on record review and interview, the facility failed to provide the resident (or representative) a fully completed Advanced Beneficiary Notice (ABN) Centers for Medicare and Medicaid Services (CMS) Form 10055 for skilled services for Resident (R) 2, R20, and R28, which included the estimated cost of services.Findings included:- The Medicare Advanced Beneficiary Notice (ABN) informed the beneficiary that they may not pay for future skilled therapy services and provided a place for a cost estimate of continued services. The form included an option for the beneficiary to (1) receive specified therapy listed, and bill Medicare for an official decision on payment. The form had a place for the resident to document they understood that if Medicare did not pay, they were responsible for payment but could appeal to Medicare. The form further documented under part (2) the resident could receive therapy listed, but would not bill Medicare, would be responsible for payment for services. Under part (3) the resident could indicate they did not want the listed therapy services.] The Center of Medicare (CMS)-10055 form provided to R2, when the skilled services ended on 07/31/25, lacked the estimated costs of service. The Center of Medicare (CMS)-10055 form provided to R20, when the skilled services ended on 11/30/25, lacked the estimated costs of services. The Center of Medicare (CMS)-10055 form provided to R28, when the skilled services ended on 12/05/25, lacked the estimated costs of services. On 12/11/25 at 11:57 AM, Administrative Staff A reported she had not dealt with beneficiary notices, but the cost should be presented for the possibility of appeal of services. The facility's Beneficiary Notices policy, dated 07/2025, documented that the standard appeals process served a similar function of enabling a beneficiary of possible non-coverage and, if Medicare agrees that coverage is not appropriate, to shift the cost of care from the Skilled Nursing Facility to the beneficiary. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN), CMS-10055, informs the resident of potential non-coverage and documents in the record that the resident understands they are accepting financial liability.

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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. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the omission of blood pressure or pulse monitoring for Resident (R) 4 prior to the administration of the antihypertensive (a class of medication used to treat high blood pressure) beta blocker (a medications that reduce the workload of the heart by slowing its rate and relaxing blood vessels) Carvedilol. The facility failed to implement recommendations made by the CP for a dosage amount for R4's Voltaren gel (a topical medication used to relieve arthritis pain). Findings included:- R4's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN- elevated blood pressure), aneurysm of the heart (a bulge in the weakened wall of the heart), traumatic brain injury (damage to the brain from an external force, like a blow, jolt, or penetrating object, causing physical, cognitive, emotional, or behavioral changes, ranging from mild to severe), and transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain) R4's admission Minimum Data Set (MDS) dated [DATE] documented R4 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R4 had impairment to one side of his lower extremities. R4 required partial staff assistance to total dependence on staff for his activities of daily living (ADL) care. R4 received an anticonvulsant (medications that control abnormal electrical activity in the brain to prevent or stop seizures). R4's Care Plan revised 08/01/25 revealed the following interventions:Staff were directed to give the resident hypertensive medications as ordered. Staff would monitor for side effects such as orthostatic hypotension (blood pressure dropping with change of position) and increased heart rate. Staff would monitor for and document any edema (swelling) and to notify the physician. Staff would monitor and record medication side effects and report to the resident's physician as necessary. Staff were directed to obtain blood pressure readings weekly, as needed and, as per protocol. Staff were to take blood pressure readings under the same conditions each time. R4's Orders tab documented a physician's order dated 04/22/25 for the beta blocker antihypertensive Carvedilol 6.25 milligrams (mg) tablet twice daily for HTN. This order lacked direction to monitor R4's blood pressure and pulse prior to administration. R4's Orders tab documented a physician's order dated 05/05/25 for Voltaren External Gel 1 % to apply to painful areas topically every six hours as needed for pain. The order was discontinued on 05/09/25. This order lacked a specified dosage amount to apply to the affected area. R4's Orders tab documented a physician's order dated 06/05/25 for Voltaren External Gel 1 % to apply to right knee, left shoulder, and neck topically four times a day for pain or discomfort. This order was discontinued on 06/18/25. This order lacked a specified dosage amount to apply to the affected area(s). R4's Orders tab documented a physician's order dated 06/18/25 for Voltaren External Gel 1 % to apply to bilateral knees topically four times a day for pain or discomfort using the supplied dosing card, apply four grams (gm) (4.5 inches) to affected area four times daily. Do not apply more than 16 gm daily to any one affected joint of the lower extremities. If applied to multiple sites, do not exceed 32 gm per day. This order was discontinued on 07/17/25. R4's Orders tab documented a physician's order dated 07/17/25 for Voltaren External Gel 1% topical to apply to bilateral knees topically four times a day for pain or discomfort using the supplied dosing card, apply four gm (4.5 inches) to the affected area four times daily. Do not apply more than 16 gm daily to any one affected joint of the lower extremities. If applied to multiple sites, do not exceed 32gm per day. And apply to left shoulder topically four times a day for pain. This order lacked a dosage amount for the left shoulder application. Review of the CP Monthly Regimen Review (MRR) from April 2025 to November 2025 revealed the CP did not identify and report that R4's blood pressure and pulse were not monitored/obtained prior to the administration of his Carvedilol. A Consultant Report dated 06/16/25 by the CP documented a recommendation for a dosage amount to apply for the ordered Voltaren gel. The 06/17/25 physician's signed response documented an acceptance for the recommendation as well as a written response to apply to the resident's lower extremity four grams four times a day. The physician did not indicate a dosage amount to be applied to the upper extremity. On 12/10/25 at 07:45 AM, R4 sat in his wheelchair in the dining room awaiting breakfast. On 12/10/25 at 09:08 AM, Certified Medication Aide (CMA) R stated she was not certain of which antihypertensive medication required either a pulse or blood pressure reading. When she obtained the reading, she reported it to the charge nurse if outside of the provided physician's parameters. On 12/11/25 at 12:02 PM, Licensed Nurse (LN) G stated that certain medications for HTN do need a blood pressure or pulse

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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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that blood pressure or pulse monitoring was obtained for Resident (R) 4 prior to the administration of the antihypertensive (a class of medication used to treat high blood pressure) beta blocker (a medications that reduce the workload of the heart by slowing its rate and relaxing blood vessels) Carvedilol. The facility failed to ensure a physician-ordered dosage amount was indicated for R4's Voltaren gel (a topical medication used to relieve arthritis pain). Finding included:- R4's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN- elevated blood pressure), aneurysm of the heart (a bulge in the weakened wall of the heart), traumatic brain injury (damage to the brain from an external force, like a blow, jolt, or penetrating object, causing physical, cognitive, emotional, or behavioral changes, ranging from mild to severe), and transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain). R4's admission Minimum Data Set (MDS) dated [DATE] documented R4 had a Brief Interview for Mental Status (BIMS) score of six, which indicated a severely impaired cognition. R4 had impairment to one side of his lower extremities. R4 required partial staff assistance to total dependence on staff for his activities of daily living (ADL). R4's Care Plan revised 08/01/25 revealed the following:Staff were directed to give the resident his hypertensive medications as ordered.Staff were directed to monitor for side effects such as orthostatic hypotension (blood pressure dropping with change of position) and increased heart rate.Staff would monitor for and document any edema (swelling) and notify the physician if identified.Staff were to monitor and record medication side effects and report to the resident's physician as necessary.Staff were to obtain blood pressure readings weekly, as needed and as per protocol.Staff were to take blood pressure readings under the same conditions each time. R4's Orders tab documented a physician's order dated 04/22/25 for the beta blocker antihypertensive Carvedilol 6.25 milligrams (mg) tablet twice daily for HTN. This order lacked direction to monitor R4's blood pressure and pulse prior to administration. R4's Orders tab documented a physician's order dated 05/05/25 for Voltaren External Gel 1 % to apply to painful areas topically every six hours as needed for pain. The order was discontinued on 05/09/25. This order lacked a specified dosage amount to apply to the affected area. R4's Orders tab documented a physician's order dated 06/05/25 for Voltaren External Gel 1 % to apply to right knee, left shoulder, and neck topically four times a day for pain or discomfort. This order was discontinued on 06/18/25. This order lacked a specified dosage amount to apply to the affected area(s). R4's Orders tab documented a physician's order dated 06/18/25 for Voltaren External Gel 1 % to apply to bilateral knees topically four times a day for pain or discomfort using the supplied dosing card, apply four grams (gm) (4.5 inches) to affected area four times daily. Do not apply more than 16 gm daily to any one affected joint of the lower extremities. If applied to multiple sites, do not exceed 32 gm per day. This order was discontinued on 07/17/25. R4's Orders tab documented a physician's order dated 07/17/25 for Voltaren External Gel 1% topical to apply to bilateral knees topically four times a day for pain or discomfort using the supplied dosing card, apply four gm (4.5 inches) to the affected area four times daily. Do not apply more than 16 gm daily to any one affected joint of the lower extremities. If applied to multiple sites, do not exceed 32 gm per day. And apply to left shoulder topically four times a day for pain. This order lacked a dosage amount for the left shoulder application. On 12/10/25 at 07:45 AM, R4 sat in his wheelchair in the dining room awaiting breakfast. On 12/10/25 at 09:08 AM, Certified Medication Aide (CMA) R stated she was not certain of which antihypertensive medication required either a pulse or blood pressure reading. When she obtained the reading, she reported it to the charge nurse if outside of the provided physician's parameters. On 12/11/25 at 12:02 PM, Licensed Nurse (LN) G stated that certain medications for HTN did need a blood pressure or pulse reading prior to being given, but not all of the physicians ordered them to be monitored. LN G stated all medications including Voltaren required a dosage for administration/application. On 12/11/25 at 12:35 PM, Administrative Nurse D stated that R4's Carvedilol was a beta blocker and did require monitoring of the blood pressure and pulse prior to administration. Administrative Nurse D stated that R4's Voltaren should have a dosage amount to indicate how much to apply to each designated area. The facility's Unnecessary Medications policy dated 04/2025 documented the residents drug regimen would be free from unnecessary drugs (any drug used in excessive dose, including duplicate therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presences of

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2's injectable medications were not expired. Findings included:- On [DATE] at 08:11 AM, during the medication/treatment cart initial tour, two Lispro injectable pens with an open date of [DATE] were noted for R2. Licensed Nurse (LN) G verified the medication was put into use on [DATE] and expired 30 days after being opened and put into use. On [DATE] 12:55 PM, Administrative Nurse D verified R2's Lispro injectable pens expired 30 days from the open date and stated the pens should be discarded. The facility's Storage of Medication policy, dated 03/2025, documented that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed per state regulation.

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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. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with one resident, Resident (R) 7, reviewed for Hospice care. Based on observation, record review, and interview, the facility failed to ensure the collaboration of care between R7's hospice provider and the facility which included the hospice provider contact information, the services the hospice provider would provide to the resident, the supplies, equipment and medications the hospice provider would provide, as well as how often hospice staff members would visit the facility. Findings included: - R7's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN- elevated blood pressure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), benign hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), and coronary artery disease (CAD- abnormal condition that may affect the flow of oxygen to the heart). R7's admission Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R7 required partial to substantial staff assistance with his activities of daily living (ADL). R7 required supplemental oxygen therapy and was on hospice services. R7's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 09/25/24 documented he required assistance with his activities of daily living (ADL), transfers, toileting, and mobility per wheelchair at times. R7 was incontinent of bowel and bladder. R7 was able to make his needs known and requested assist as needed. R7 admitted to the facility on Hospice Services for end-stage CAD. R7's Care Plan revised 10/02/25 directed staff he was receiving hospice services. The plan of care directed staff to adjust provision of ADLs to compensate for the resident's changing abilities. Staff were to encourage resident participation to the extent the resident wishes to participate. The plan of care directed staff to assess R7's coping strategies and respect resident wishes. The plan of care directed staff to consult with the physician and Social Services to have Hospice care for resident in the facility. The plan of care directed staff to encourage R7 to express feelings, listen with non-judgmental acceptance, compassion. The plan of care directed staff to encourage a support system of family and friends. The plan of care directed staff to observe resident closely for signs of pain, administer pain medications as ordered, and notify the physician immediately if there the plan of care directed staff to refer for Psychiatric consult if indicated. The plan of care directed staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs was met. The plan of care directed staff to work with nursing staff to provide maximum comfort for the resident. The Plan of Care lacked staff direction regarding the hospice providers contact information. The plan of care lacked staff direction on what hospice staff would visit R7 at the facility or how often. The plan of care lacked staff direction on the supplies and durable medical equipment, and medications provided by the hospice provider. R7's Orders tab documented a physician's order dated 09/12/25 to admit to the facility and hospice services. On 12/10/25 at 09:27 AM, R7 sat in his wheelchair in the hallway awaiting to go outside for his smoke break. On 12/11/25 at 10:35 PM, Certified Nurse Aide (CNA) M stated typically the nurse would let staff know which resident (s) was on hospice. CNA M stated she did not have access to the care plan but did know that hospice did provide supplies like briefs, bed mattresses, and stuff like that. CNA M stated usually the nurse would tell staff when hospice would be visiting. On 12/11/25 at 12:02 PM, Licensed Nurse (LN) G stated R7's care plan did mention he was on hospice but could not say if it had direction as to what supplies hospice provided or when hospice staff would visit. On 12/11/25 at 12:35 PM, Administrative Nurse D stated she expected R7's Care Plan to direct staff on when hospice providers would visit, and what supplies hospice provided and such. Administrative Nurse D stated she would ensureR7's care plan was updated with that information. The facility's Hospice Program policy, dated October 2024, documented the community retained the ultimate responsibility for the care plan. The policy documented to promote continuity of care, collaboration with the hospice, nursing home and resident/representative on a coordinated care plan noted in the medical record. Although, the Hospice provider retained the primary responsibility for the provision of the following hospice care and services, including but not limited to, the community must coordinate the care and ensure the resident received all necessary care and services; providing medical direction and management of the resident; nursing, including assigning a hospice aide as needed support; counseling; social work; providing medical supplies, durable medical equipment; medications necessary for palliation of pain and

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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 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 34 residents, with 12 included in the sample. Based on observation, record review, and interview, the facility failed to ensure nursing staff donned (put on) the appropriate required Enhance Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) before providing direct cares to Resident (R) 5 and ensure staff did not set R5's catheter bag (medical device that collects urine) directly on the resident's floor. The facility failed to ensure nursing staff donned the required EBP and performed hand hygiene prior to and during the wound dressing change for R15. Findings included:- On 12/10/25 at 11:23 AM, Licensed Nurse (LN) G gathered and prepared wound care supplies (placed gauze pads into a clean plastic cup and placed zinc ointment into a clean cup) on the treatment cart outside of R15's room. LN G gathered the wound care supplies in her hands as she knocked on R15's door to announce herself and explained she was going to change the dressing for his pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, a result of pressure, or pressure in combination with shear and/or friction) on his right buttock. LN G then placed the cups and wound supplies directly onto R15's bedside table, as well as the sealed dressing package. LN G failed to don (put on) a clean gown, as required, due to R15's Enhanced Barrier Precaution (EBP) status. LN G failed to wash her hands or perform hand hygiene before she donned clean gloves and removed the old bandage from R15's bottom. LN G removed her gloves and placed them in the trash and donned a clean pair of gloves, without performing hand hygiene. LN G then grabbed the wound cleanser bottle to spray the wound area and wiped the area with a clean gauze pad from the cup on the bedside table. LN G removed the dirty gloves and disposed of them in the trash. LN G did not perform hand hygiene before she donned clean gloves. LN G applied the zinc to the wound bed. LN G opened the new dressing bandage, wrote the date on the bandage, removed the adhesive tab covers, and applied the dressing to the wound area. LN G rolled R15 back over to his back and refastened his brief. LN G disposed of the dressing supplies in the trash, removed her gloves, and exited the room. LN G did not wash or sanitize her hands after exiting R15's room. On 12/11/25 at 12:02 PM, LN G stated she should have put on a gown as she entered R15's room and she had not realized she did not put one on or that she did not perform hand hygiene. On 12/11/25 at 12:35 PM, Administrative Nurse D stated she expected her nursing staff to put on all the appropriate EBP when performing direct cares on residents, including putting on a gown. Administrative Nurse D stated she expected staff to perform appropriate hand washing and hand hygiene during any cares. The facility's Infection Prevention and Control Program policy, dated 01/2024, documented the community Infection Prevention and Control Program was designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The community program would follow accepted national standards. Components of the program would include (see appropriate Policy and Guidelines): Surveillance system; reporting requirements; use of standard and transmission-based precautions; employee health; hand hygiene; environmental cleaning; occupational health; antibiotic stewardship; recording system; and annual review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175205	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilson Care and Rehab	611 31st Street Wilson, KS 67490

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- During an observation on 12/10/25 at 03:50 PM, Certified Nurse Aide (CNA) M entered R5's room and retrieved gloves from the Enhanced Barrier Precaution (EBP) supply hanger on the door, but did not don a gown. CNA M asked R5 if she had permission to empty the catheter bag. R5 agreed to have his catheter bag drained. CNA M proceeded to don gloves, retrieve a measuring device from the bathroom, and empty the catheter drainage bag. CNA M placed the catheter drainage bag on the floor under R5's wheelchair while she obtained a privacy bag to hook under the wheelchair, after which CNA M washed her hands. CNA M lacked the use of an EBP gown during caring for the catheter drainage bag. On 12/11/25 at 11:19 AM, Administrative Nurse F verified staff should wear gloves and gowns while caring for R5's catheter, and the drainage bag should not lie on the floor. On 12/11/25 at 12:55 PM, Administrative Nurse D verified the use of a gown and gloves during care of catheters, and the drainage bag should not have been left lying on the floor. The facility's Indwelling Urinary Catheters policy, dated 05/2025, documented use of standard precautions when handling or manipulating the drainage system. The policy documented to be sure the catheter tubing and drainage bag were kept off the floor.