STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175208	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Care and Rehab	1005 E Centennial Drive Pittsburg, KS 66762

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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 had a census of 60 residents. Based on observation, interview, and record review, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as air-conditioning units in large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease or heavy tobacco use are most at risk of developing a pneumonia caused by legionella). Findings included:- On 03/11/26 at 10:04 AM, Maintenance Staff V reported the facility utilized a Legionella testing kit, which was conducted on 12/22/25 from the kitchen water. The final report, dated 12/30/25, did not detect Legionella. Maintenance Staff V verified the facility did not have documentation of a map from which the facility's source of incoming water, a flow diagram of the water flow of the facility, or areas of designated dead-end water areas in which the water may stagnate. The facility's Water Management, Legionella Testing policy, dated10/2022, documented approaches to controlling waterborne microorganisms (i.e., water systems decontamination) will be consistent with current Centers for Disease Control and Prevention (CDC), Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Food and Drug Administration (FDA) recommendations or state and local health department requirements.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility identified a census of 60 residents. The sample included 15 residents with one resident reviewed for dignity. Based on interviews, observation, and record review the facility failed to ensure Resident (R) 9 was treated with respect, dignity, and care during mealtimes.Findings included:- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods).R9's Significant Minimum Data Set (MDS) dated 12/28/25 documented a Brief Interview of Mental Status (BIMS) score of 99; a staff interview was completed which indicated the resident had severely impaired cognition. R9's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/02/26, documented she had a diagnosis of dementia and received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication daily.R9's Care Plan, documented the following interventions: 04/15/25- staff would provide set up assistance to supervision, with assistance from one staff.11/12/25-someone must sit and assist her with every meal and snacks three times a day for weight loss. R9?s EMR under the Orders tab revealed the following physician orders:12/24/25 Assist the resident with meal intake every meal.On 03/10/26 at 08:37 AM, R9 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Certified Nurse Aide (CNA) M stood next to R9's chair and attempted to assist her with breakfast.On 03/11/26 at 12:44 PM, Certified Medication Aide (CMA) R stated nursing staff should be seated next to the residents they were assisting with meals. CMA R stated the nursing staff should be engaging the residents in conversation.On 03/11/26 at 12:55 PM, Licensed Nurse (LN) I stated the staff should be seated next to the residents when assisting with meals. LN I stated they should be at eye level and visit with resident during meals.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility identified a census of 60 residents. The sample included 15 residents with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interviews, the facility failed to provide form CMS-10055, Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN), which included the estimated cost for continued services for skilled services to the resident or their representative for Resident (R) 36 and R44.Findings included:- Review of R36's Electronic Medical Record (EMR) documented the Medicare Part A episode began on 01/08/26 and ended on 02/09/26. The ABN dated 02/09/26 lacked a daily rate for services. R36 remained in the facility for custodial care.Review of R44's Electronic Medical Record (EMR) documented the Medicare Part A episode that began on 08/25/25 and ended on 11/07/25. The ABN dated 11/05/25 lacked a daily rate for services. R44 remained in the facility for custodial care.On 03/11/26 at 08:11 AM, Administrative Nurse E stated she was responsible for issuing the ABN notices to the residents at the time for discharge from skilled therapy. Administrative Nurse E stated she had been instructed not to include the daily rate for services by the regional manager, related to the price fluctuation of the rate.On 03/11/26 at 12:40 PM, Administrative Staff A stated the facility did not include the rate for services on the ABN notices related to changing the rate.The facility's Beneficiary Notices policy, last approved 07/2025, documented a Medicare beneficiary had the right to have Medicare make the decision to determine if skilled services would not be covered by Medicare. Two processes are available: the expedited appeals process and the standard appeals process. The expedited appeals process was intended to keep Medicare-covered services continuing, without interruption. The standard appeals process serves a similar function of enabling a beneficiary to seek Medicare payment for a SNF stay, but it was also necessary to inform the beneficiary of possible non-coverage and, if Medicare agrees that coverage was not appropriate, to shift the costs of care from the SNF to the beneficiary.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. The facility had a census of 60 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to keep the residents protected health information (PHI) private on two medication carts parked in the west hallway and the east hallway.Findings included:- On 03/11/26 at 11:31 AM, an observation revealed a medication cart parked in the east hallway with the laptop computer sitting on top. The computer screen was unlocked, and a resident's PHI was on the screen, visible to all who passed by the medication cart. The information visualized included medications, date of birth , allergy information, and code status. No nursing staff were in view of the medication cart.On 03/11/26 at 12:40 PM, an observation revealed a medication cart parked in the west hallway with the laptop computer sitting on top. The computer screen was unlocked, and a resident's PHI was on the screen, visible to all who passed by the medication cart. The information visualized included medications, date of birth , allergy information, and code status. No nursing staff were in view of the medication cart.On 03/11/26 at 12:55 PM, Licensed Nurse (LN) H stated she was always careful not to leave the computer open to a resident's PHI. LN H stated the medication cart should be locked, and the computer laptop should be cleared, or the computer should be closed when staff walk away from the medication cart.On 03/11/26 at 12:55 PM, Licensed Nurse (LN) I stated the medication cart should be locked, and the laptop computer screen lid should be closed, or the residents PHI should be cleared from the computer screen if the nursing staff walked away from the medication cart.On 03/11/26 at 02:34 PM, Administrative Nurse D stated she expected the laptop computer screen to be closed, or residents' information cleared from the computer screen when the staff would not be working at the medication cart.The facility's Confidentiality and Privacy of information policy, last approved 10/2025 documented the facility would treat all resident information confidentially. The resident had a right to personal privacy and confidentiality of his or her personal and medical records. The facility would safeguard all resident records, whether medical, financial, or social in nature, to protect the confidentiality of the information.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. The facility identified a census of 60 residents. The sample included 15 residents with five residents reviewed for unnecessary medications. Based on interviews, observation, and record review the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R)4 and R19, who had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).Findings included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).The Quarterly Minimum Data Set (MDS) dated 01/04/26 documented a Brief Interview of Mental Status (BIMS) score of 99; a staff interview was completed which indicated the resident had severely impaired cognition. The MDS documented R4 had received antipsychotic medication, antidepressant (a class of medications used to treat mood disorders) medication, anticonvulsant (a medication that prevents or treats seizures and convulsions) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period.R4's Psychotropic Drug Use Care Area Assessment (CAA), dated 07/05/25, documented she had a diagnosis of dementia and received an antipsychotic medication daily.R4's Care Plan documented the following interventions: 01/30/25- administer medications as ordered.R4?s EMR under the Orders tab revealed the following physician orders:01/22/26 -Zyprexa (antipsychotic) oral tablet 2.5 milligram (mg) (Olanzapine) give two tablets via percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) two times a day for combative behavior, hitting, and/or scratching. May be given by mouth if resident accepts before giving via PEG-tube.Review of R4's clinical record lacked physician documentation of risk versus benefit of administration of antipsychotic medication with a non-approved indication of use for R4, who had a diagnosis of dementia. The facility was unable to provide the physician documentation upon request. The facility did provide a Consent for use of Psychoactive Medication Therapy form, which lacked the physician documentation for the continued use with a non-approved indication.On 03/10/2026 at 07:28 AM, R4 laid on her right on her high/low bed. R4's bed was lowered to the floor, and she was covered up with the blankets pulled up to her shoulders. R4 laid on her H/L bed lowered to the floor, blankets pulled up to her shoulders.2.R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R19's Quarterly Minimum Data Set (MDS) dated 01/31/26 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R19 received hospice services during the observation period. The MDS documented R19 had received antipsychotic medication, antidepressant (a class of medications used to treat mood disorders) medication, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period. R19's Psychotropic Drug Use Care Area Assessment (CAA), dated 05/07/25, documented she had a diagnosis of dementia and had received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication daily.R19's Care Plan documented the following intervention:12/08/24 -administer medications as ordered.R19?s EMR under the Orders tab revealed the following physician orders: 12/03/24 - Olanzapine (antipsychotic) tablet five milligram (mg), give one tablet by mouth at bedtime (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for a psychotic disorder.Review of R19's clinical record lacked physician documentation of risk versus benefit of administration of antipsychotic medication with a non-approved indication of use for R19 who had a diagnosis of dementia. The facility was unable to provide the physician documentation upon request. The facility did provide a Consent for use of Psychoactive Medication Therapy form, which lacked the physician documentation for the continued use with a non-approved indication.03/10/26 at 08:44 AM, R19 sat at the dining room table upright in her Broda chair (specialized wheelchair with the ability to tilt and recline). R19 fed herself breakfast.On 03/11/26 at 02:34 PM, Administrative Nurse D stated R4 and R19 had been followed by telehealth for psychiatric therapy for antipsychotic medication usage. R19 had been discharged from the telehealth therapy on 11/20/25, related to her being unable to participate with the therapy.The facility's Use of Psychotropic Drugs policy, effective 05/2025 documented residents would only receive psychotropic or other approved medications that have an effect on brain activity when necessary to treat specific conditions for which they are indicated and effective and would not be used for discipline or convenience of the staff. Residents and/or their representative have the right to refuse such treatment.

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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 60 residents. The sample included 15 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) 9 with the admission to hospice services. Findings included:- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods).R9's Significant Minimum Data Set (MDS) dated 12/28/25 documented a Brief Interview of Mental Status (BIMS) score of 99; a staff interview was completed which indicated the resident had severely impaired cognition. R9's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/02/26 documented she had a diagnosis of dementia and received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication daily.R9's Care Plan documented the following interventions: 014/28/26 - Hospice would provide extra bathing on Monday and Thursday.The care plan lacked other services provided by hospice.R9?s EMR under the Orders tab revealed the following physician orders:01/21/26 - Hospice of family's choice to evaluate and treat.On 03/10/26 at 08:37 AM, R9 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Certified Nurse Aide (CNA) M stood next to R9's chair and attempted to assist her with breakfast.On 03/11/26 at 01:51 PM, Administrative Nurse E stated R9 had been admitted on to hospice services on 01/22/26. Administrative Nurse E stated she had completed a significant change MDS prior to R9's admission to hospice. Administrative Nurse E stated she should have completed another significant MDS after R9's admission to hospice.On 03/11/26 at 02:34 PM, Administrative Nurse D stated the significant change MDS was not completed at the time of R9's admission to hospice. Administrative Nurse D stated Administrative Nurse E had completed a significant change for R9 when she had a significant change in her health status.The facility's Electronic Transmission of the MDS policy, effective date of 10/2025, documented the MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) would be transmitted per state and federal guidelines.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 60 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to ensure adequate pain management was provided to Resident (R) 41 for ongoing pain in the knees, lower back, and shoulders.Findings included:- R41 Electronic Medical Record (EMR) documented R41 had diagnoses of cardiomyopathy (heart disease), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), need assistance with personal care, and muscle weakness.R41's Quarterly Minimum Data Set (MDS), dated [DATE], documented R41 had intact cognition. The MDS further documented R41 received scheduled pain medication regimen, no as needed medication, and received a nonpharmacological intervention for pain. R41 had pain frequently at a pain level of 10 (pain scale, which 0 is no pain to 10, which is the worst pain) that occasionally affected R41's s sleep. The MDS documented R41 received scheduled pain medication regimen, nonpharmacological interventions, and no as needed medication. R41 received an antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), diuretic (a medication to promote the formation and excretion of urine), opioid (medications used to treat pain), and hypoglycemic (a class of medication used to lower blood sugar levels).R41's Pain Care Area Assessment (CAA), dated 11/17/25, documented he took an opioid every six hours for low back pain, monitored every shift and as needed for any pain he may have.R41's Care Plan dated 03/26/26, noted he received opioid medication for chronic joint and lower back pain. The plan directed staff to assess pain type, location, and characteristics before and after administration of as needed medication. The plan further documented long-acting opioid use was appropriate for R41 based upon his history. The plan lacked direction to staff of nonpharmacological intervention for pain.The Physician Order dated 01/22/26, instructed staff to administer hydrocodone (opioid)-acetaminophen 10-325 milligrams (mgs) tablet by mouth every six hours for low back pain.The Physician Order dated 12/31/25 directed staff to apply diclofenac sodium external gel (topical medication used for pain relief), four grams to right knee three times a day for right knee pain.The Physician Order dated 05/28/25, instructed staff to monitor pain every shift related to use of as needed hydrocodone use.The Physician Orders lacked a prescription for as needed medication for R41's breakthrough pain or discomfort.The Physician Progress Note dated 10/23/25, documented R41 seen for pain level or 10. R41 reports pain in right leg and knee, R41 described as achy and pins/needles and increased movement. R41 currently takes hydrocodone 10 mg every six hours.On 03/09/26 at 12:05 PM, R41 lying on his bed, reported significant pain in his joints, knees, shoulders and lower back. R41 stated he received pain medication routinely but continued to experience severe pain at times.On 03/11/26 at 09:11 AM, Certified Nurse Aide (CNA) Q reported R41 did not always verbalize pain, but CNA Q stated she could tell he was having pain by 41's facial expression and his appetite would decrease. CNA Q stated when this happens, she notifies the nurse in charge.On 03/11/09:15 AM, Licensed Nurse (LN) H verified the physician orders lacked as needed medication for R41, and at times reported pain level at 10. LN H reviewed the physician order and Care Plan lacked direction to staff for nonpharmacological interventions for pain relief.On 03/11/26 at 02:33 PM, Administrative Nurse D reported R41 had been placed on routine hydrocodone, had no breakthrough pain medication or interventions in the Care Plan for nonpharmacological interventions for pain. Administrative Nurse D reported no assessment of R41's acceptable pain levels or consultation for R41's ongoing pain.The facility's Unnecessary Medication policy, dated 04/25, documented any drug used in excessive duration based on assessment of the resident's condition and therapeutic goals and after any safer treatments have been deemed clinically contraindicated.

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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. The facility identified a census of 60 residents. The sample included 15 residents with two residents reviewed for hospice services. Based on interviews, observation, and record review, the facility failed to ensure collaboration with the hospice provider for Resident (R) 19 and R9.Findings included:- R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R19's Quarterly Minimum Data Set (MDS) dated 01/31/26 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R19 received hospice services during the observation period. R19's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/07/25, documented she had a diagnosis of dementia and had received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication on a daily basis.R19's Care Plan documented: 04/30/25 Consult with the physician and social services to have hospice care in the facility.Staff would encourage her to express her feelings, listen with non-judgmental acceptance and compassion. Encourage a supportive system of family and friends.01/16/26 Oxygen is needed for comfort. Observe her closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain.R19's EMR under the Progress Note tab revealed a Nursing note on 04/29/25 at 09:18 PM R19 was admitted to hospice.03/10/26 at 08:44 AM, R19 sat at the dining room table upright in her Broda chair (specialized wheelchair with the ability to tilt and recline). R19 fed herself breakfast.2. R9's EMR from the Diagnosis tab documented diagnoses of dementia, major depressive disorder, anxiety, and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods).R9's Significant MDS dated 12/28/25 documented a BIMS score of 99; a staff interview was completed which indicated the resident had severely impaired cognition. R9's Cognitive Loss/Dementia CAA dated 01/02/26, documented she had a diagnosis of dementia and received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication daily.R9's Care Plan documented the following interventions:014/28/26 Hospice would provide extra bathing on Monday and Thursday.The care plan lacked other services provided by hospice. R9?s EMR under the Orders tab revealed the following physician orders:On 01/21/26, hospice of family's choice to evaluate and treat.On 03/10/26 at 08:37 AM, R9 sat in her Broda chair at the dining room table. Certified Nurse Aide (CNA) M stood next to R9's chair and attempted to assist her with breakfast.On 03/11/26 at 01:51 PM, Administrative Nurse E stated R9 had been admitted on to hospice services on 01/22/26.On 03/11/26 at 12 PM, Certified Medication Aide (CMA) R stated the nurses informed the staff which residents received hospice services. CMA R stated she could find the information of what hospice provided for the residents in the book that was provided by hospice. CMA R stated the services provided by hospice should be included in the residents' care plan.On 03/11/26 at 12:55 PM, Licensed Nurse (LN) I stated the information of what services are provided by hospice could be found in the book that was provided by hospice. LN I stated it would be helpful if the residents' care plan had the services provided by hospice.On 03/11/26 at 02:34 PM, Administrative Nurse D stated the facility did include some of the services provided by hospice on the resident's care plan. Administrative Nurse D stated the facility did not include all the services provided by hospice.The facility's Hospice Program policy, approved of 12/2025 documented the facility may contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. The facility may limit the hospice providers in relation to the coordination and communication of care within the facility.