STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175215	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 70 residents. The sample included 18 residents, with one reviewed for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to initiate effective interventions to prevent the development of the left lateral (pertaining to the side, away from the middle) foot and left middle toe facility acquired pressure ulcers for Resident (R) 44.Findings included: - R44's diagnoses included metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), fracture right femur (thigh bone), pneumonia (a lung infection that causes inflammation and fluid or pus to fill the air sacs of the lungs), and nicotine dependency. R44's admission Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R44 was dependent on staff with activities of daily living (ADL), used a wheelchair for mobility, and required staff supervision in the facility. The MDS documented the resident had a pressure ulcer, was at risk for developing pressure ulcers, had one Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer that was present upon admission. The MDS documented R44 had a pressure reducing device for his chair received pressure ulcer/injury care with application of non-surgical dressings. R44's Activities of Daily Living Care Area Assessment (CAA) dated 12/22/25 documented the resident required substantial assistance with toileting, bathing, dressing, bed mobility, and transfers. The CAA documented the resident as non-ambulatory, required a wheelchair for all mobility and used stand pivot method for transfer. The CAA documented the residents was alert and oriented. R44's Pressure Ulcer CAA dated 12/22/25 documented the resident admitted with a Stage 3 pressure wound on his coccyx (area at the base of the spine), a surgical wound to his right hip, and an unstageable pressure wound on his right heel. R44's admission Braden (a clinical tool that assesses a resident's risk for developing pressure injuries) was 16. (a score of 16 indicated a mild risk to develop pressure ulcers) The resident had a pressure reduction mattress, which was changed to a low air loss mattress due to his wounds, and he required significant assistance of one staff for turning and repositioning. R44 had a cushion to his wheelchair and was to offload/shift weight while up in his chair. R44 would be followed by wound nurse practitioner until wounds are healed. R44's Care Plan dated 12/28/25 documented R44 had a cushion in his wheelchair and was able to shift his weight/offload while up in a chair. The care plan documented R44 had a pressure-reducing mattress and was able to turn and reposition with substantial assistance from staff. Staff would complete a Braden assessment upon admission, quarterly, and as needed to identify any risk for skin issues. Staff would complete a weekly skin assessment and would monitor R44's skin with all cares. R44's care plan documented the resident as non-ambulatory and used a wheelchair for all mobility. Staff would push the resident in his wheelchair for longer distances, and he could propel himself for shorter distances. The Braden Scale Assessment for predicting pressure ulcer risk dated 12/16/25 documented a score of 16.0, which indicated the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident had a risk of pressure injury development. The Braden Scale Assessment for predicting pressure ulcer risk dated 01/12/26 documented a score of 20.0, which indicated the resident did not have a risk of pressure injury development. The Weekly Skin Observation dated 12/16/25, documented R44 admitted to the facility with a right heel wound, coccyx wound, and surgical incision on the right thigh with no signs or symptoms of infection noted. The Wound Assessment Details Report dated 01/08/26 document R44 had an unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) facility acquired, pressure injury on the left middle toe that measured 2.00 centimeters (cm) by 1.00 cm by 0.01 cm with hard necrotic (pertaining to the death of tissue in response to disease or injury) tissue present. The Wound Assessment Details Report dated 01/08/26 documented R44 had a facility acquired, deep tissue pressure injury to the left lateral outer foot that measured 4.00 cm by 5.00 cm by 1.00 cm. The Weekly Skin Observation dated 01/13/26 documented R44 had a coccyx wound, open area to his left knee, open area to the left inner, and the back of heel-but failed to document right or left and lacked any further description of the wound. The Physician Order dated 01/13/26 directed staff to send R44 to the emergency department for evaluation and treatment of the left lower leg wounds and swelling. The Wound Assessment Details Report dated 01/28/26 documented R44 had a facility acquired, unstageable pressure injury to the left middle toe that measured 2.00 cm by 1.00 cm by 0.01 cm, with hard necrotic tissue. The Wound Assessment Details Report dated 01/29/26 documented R44 had a facility acquired, pressure injury to the left lateral outer foot that measured 2.00 cm by 4.00 cm by 0.01 cm. After review of the medical records, it was revealed R44 only had two weekly skin observations since admission on [DATE] (six weeks ago). The Physician Order dated 01/12/26 documented staff would change the dressing to R44's left lateral foot, cleanse with wound cleanser, gently pat dry with gauze, Skin-prep (liquid skin protectant) around the peri wound (skin surrounding the wound), cut calcium alginate (highly absorbent dressing) to size, apply to wound bed, and cover with a 4 x 4 bordered foam dressing to the area, change once a day and as needed. The Physician Order dated 01/28/26 documented staff would change the dressing to R44's left middle toe, cleanse with wound cleanser, pat dry, apply calcium alginate to the wound bed only, cover with dry dressing, change daily, and/or as needed. On 01/28/26 at 01:05 PM, R44 laid in be on his back. License Nurse (LN) G cleansed the left middle toe with wound cleanser, dried the area with a gauze sponge, then applied calcium alginate to the wound bed and secured with a band-aid. The left middle toe had a black area approximately one-fourth of an inch by one-fourth of an inch on the distal (away from the farthest point of origin or attachment) side of the toe with a small amount of serous (thin, clear) drainage and the entire toe appeared swollen and red. R44 complained of discomfort with the dressing change. Continued observation revealed LN G cleansed the open area on R44's lateral left foot with wound cleanser. The wound appeared as a one-half inch round open area. LN G dried the area with a gauze sponge, then applied calcium alginate to the wound bed and secured with bordered foam dressing. The open area had a small amount of serous drainage with redness around the open wound. On 01/28/29 at 09:05 AM, Administrative Nurse E verified R44 developed the facility acquired, pressure ulcer on his left middle toe and left lateral foot approximately four weeks after admission to the facility. Administrative Nurse E verified R44 admitted to the facility with a coccyx wound and left heel wound. Administrative Nurse E verified the facility assessed the resident with a Braden Assessment, that documented the resident as at risk and the last one documented the resident as not at risk for pressure ulcer development. She stated they should have assessed the resident for being at risk of pressure ulcers. Administrative Nurse E verified the resident had a low air loss mattress but lacked any pressure relieving boots upon admission and stated he should have those to protect his skin. The Pressure Injury Prevention Guidelines, policy dated 01/02/26, documented the facility would prevent the formation of avoidable pressure injuries and promote healing of existing pressure injuries and it was the policy of the facility to implement evidenced-based interventions for all residents who are assessed at risk or who have a pressure injury present. The policy documented interventions (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	would be implemented in accordance with physician orders, including the type of preventative devices to be used and, for tasks, the frequency for performing them. Preventative devices would be utilized in accordance with manufacturer recommendations, such as heel flotation devices, cushions, and mattresses. Interventions would be documented in the care plan and communicated to all staff. The effectiveness and interventions would be monitored through ongoing assessment of the resident and/or wound, and consideration for needed modification includes development of a new pressure injury, lack of progression towards healing or change in wound characteristics, and changes in the resident's goals and preferences, such as at end-of -life or in accordance with his/her rights.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. The facility had a census of 70 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to inform the residents of the posting of the Ombudsman (an independent, neutral official who investigates, reports on, and helps resolve complaints) and State Agency contact numbers.Findings included:- On 01/27/26 at 01:15 PM, the State Agency and Ombudsman information posters were located in the front portion of the building lobby/hallway area. The resident council minute review from 01/2025 through 01/2026 lacked information regarding the Ombudsman and State Agency posting.On 01/28/26 at 03:29 PM, the Resident Council President, Resident (R) 12, reported that the council had not been informed of the Ombudsman and State Agency contact information.On 01/29/26 at 11:45 AM, Activity Staff Z reported sharing information regarding the Ombudsman and State Agency reporting during the resident council meetings, but had not recorded this information in the resident council meeting minutes.On 01/29/26 at 01:45 PM, Administrative Staff A stated the information should be reviewed with the council at least annually.The facility's undated Posting of Ombudsman and State Agency policy documented that the facility shall prominently post all required Ombudsman and state agency notices in locations that are readily accessible and visible to residents, resident representatives, and the public. Posting shall be reviewed at least annually and whenever there is a change in contact information or regulatory requirements.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. The facility had a census of 70 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to inform the resident council of the state inspection report.Findings included:- On 01/27/26 at 01:15 PM, the State Agency inspection book was located in the front lobby. The resident council minutes' review from 01/2025 through 01/2026 lacked information regarding the location of state inspection results.On 01/28/26 at 03:29 PM, the Resident Council President, Resident (R) 12, reported that the council had not been informed of the location of the state inspection results.On 01/29/26 at 11:45 AM, Activity Staff Z reported she had not included the location of the State Agency's inspection report. Activity Staff Z reported sharing information regarding the Ombudsman and State Agency reporting during the resident council meetings, but had not recorded this information in the resident council meeting minutes.On 01/29/26 at 01:45 PM, Administrative Staff A stated the information should be reviewed with the council at least annually.The facility's undated Resident Rights policy document the facility informed the residents both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during their stay in the facility. The resident has a right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of corrections in effect with respect to the facility.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility had a census of 70 residents. Based on observation, interview, and record review, the facility failed to conduct a thorough facility-wide assessment to determine necessary care for residents competently during both day-to-day operations and emergencies.Findings included:- On 01/28/26 at 09:00 AM, Administrative Staff A reported looking for the assessment but had not located it when the facility assessment was requested a second time.On 01/29/26 at 10:00 AM, Administrative Staff A reported that she could not locate the facility assessment, which she had completed and provided for the survey process on 01/27/26, along with a Quality Assurance Assessment (QAA) committee to be reviewed on 02/18/26.The facility's Facility Assessment policy, dated 04/01/25, documented that the facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The purpose of the policy is to establish responsibilities and procedures for the facility assessment process. The facility assessment would be reviewed and updated as necessary and at least annually, or whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 70 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to place an open date on the Lantus (long acting insulin) pen (disposable, prefilled injection pen) in one of two nurse medication carts. The facility failed to consistently record refrigerator temperatures in the medication room. The facility further failed to lock an emergency (ER) cart, which had medications accessible to residents, with an expired Narcan (a medication that readily reverses an opioid, a narcotic pain medication).Findings included:- On [DATE] at 08:30 AM, observation revealed, in the 400 hall nurse medication cart, Resident (R) 58's Lantus pen lacked an open date. On [DATE] at 08:30 AM, Licensed Nurse (LN) K verified the Lantus pen was open, and stated staff should date a Lantus pen when they open it. On [DATE] at 02:00 PM, Administrative Nurse D stated staff should date insulin pens when they open them The facility's Medication Storage Policy, revised 2025, documented the facility would ensure all medications housed on its premises would be stored in the pharmacy and /or medication rooms according to the manufacturer's recommendations. - On [DATE] at 08:30 AM, during an initial tour of the facility's south medication room, the medication refrigerator temperature log had only been posted for [DATE] to 26th, had only recorded temperature on [DATE]st, 2nd, 3rd, 4th, 12th, and 20th. Licensed Nurse (LN) G reported that the refrigerator temperature readings were to be checked by the night shift nurses each night. On [DATE] at 08:53 AM, during an initial tour of the facility, a treatment cart located in the middle hall between the north and south sides of the building was found unlocked. The top drawer stored Naloxone HCL Nasal Spray (a medicine that rapidly reverses an opioid overdose) with an expiration date of 06/2025. The second drawer contained a container of Liquid Skin (topical skin treatment) and Derma Clenz (wound cleaner) with instructions to keep out of reach of children. During inspection of the cart, Administrative Staff A verified that the label of Naloxone HCL Spray had expired, and the Liquid Skin and Derma Clez had instructions to keep out of reach of children. Administrative Staff A stated that the treatment care should be locked. Administrative Staff A locked the cart at that time. On [DATE] at 02:30 PM, Administrative Nurse E verified that the medication room refrigerators should be checked and recorded daily by the night shift nurses, and the treatment cart should be locked when not in use. The facility's undated Medication Storage policy documented that all drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized personnel will have access to the keys to locked compartments. During a medication pass, medications must be under direct observation of the person administering medications or locked in the medication storage area/cart. Temperatures are maintained within 36-46 degrees Fahrenheit. Charts are kept on each refrigerator, and temperature levels are recorded daily by the charge nurse or other designee.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 70 residents. Based on observation, interview, and record review, the facility failed to prepare and serve food in a sanitary manner when dietary staff did not complete hair coverage with the hairnet and beard cover. This deficient practice placed the residents of the facility who received meals from the facility at risk for food borne illness. Findings included: - On 01/27/26 at 08:00 AM, observation revealed dietary staff in the facility kitchen preparing and serving breakfast to the residents. Dietary Staff (DS) CC had a beard and mustache and lacked a beard or facial cover while preparing drinks for the residents. On 01/28/26 at 11:00 AM, observation revealed DS DD had a beard and mustache and wore a beard cover but did not cover his mustache and was washing the dishes and preparing salads for lunch. On 01/28/26 at 11:40 AM, observation revealed DS EE walked through the dining room door to the back of the kitchen and grabbed a hair net then proceeded to walk through the kitchen where the staff were preparing the lunch meal and rolled her mid length hair in a low bun then put her hair in the hair net. On 01/28/26 at 11:45 AM, DS BB stated DS EE waked through the kitchen before she wore a hair net and stated staff were to wear hairnets while in the kitchen. DS BB verified DSCC lacked a beard and moustache cover and should cover beards, and have thorough hair coverage including mustaches with a beard/facial cover. The facility's Food Safety and Sanitization policy, undated, documented food would be stored, prepared, distributed and served in accordance with professional standards for food service safety. Food safety practices would be followed throughout the facility's entire food handling process. The process begins when the food is received from the vendor and ends with delivery of the food to the residents. During food preparation staff will take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects, dietary staff must wear hair restraints including hairnets, hat, and/or beard restraint to prevent hair from contacting food.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. The facility had a census of 70 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility's Quality Assessment and Assurance (QAA) program failed to provide good faith efforts to identify multiple issues of concern for 33 residents residing in the facility.Findings included:-The facility failed to document the review of resident rights with the resident council. Refer to F 574.The facility failed to inform the resident council where the survey result book or contact the ombudsman and the state agency was kept. Refer to F577.The facility failed to prevent the misappropriation of R16's Morphine. Refer to F600.The facility failed to provide R2, R4, and R74 a bed hold notification and failed to notify the ombudsman when they were transferred to the hospital. Refer to F628.The facility failed to update R3's Care Plan when R3 received a leg injury to prevent further leg injuries. The facility failed to update R44's care plan with a smoking section. Refer to F657.The facility failed to consistently provide R69 and R20 bathing as per their preferences. Refer to F677.The facility failed to provide R6 with treatment when his blood sugar was in the 30's. The facility further failed to document the condition of R20 before ER/hospitalization. The facility further failed to provide documentation regarding R3, who was transferred to the ER, resulting in 17 sutures to his leg. Refer to F684.The facility failed to provide interventions to prevent R44's middle toe and left lateral foot pressure ulcer. Refer to F686.The facility further failed to provide R44 with a smoking assessment. Refer to F 689.The facility failed to have a system to prevent the diversion of liquid morphine. Refer to F755.The facility failed to label a Lantus pen with an open date. The facility further failed to lock an ER cart, which had Narcan expired 06/25 and liquid skin and derma cleanse accessible to residents. The facility further failed to consistently document refrigerator temperatures in one of two medication rooms. Refer to F761.The facility failed to procure, store, prepare, and keep the kitchen sanitary when one dietary aide lacked a beard cover, one lacked a mustache cover, and two dietary aides had stocking caps as hair covers. Refer to F812.The facility failed to establish a facility assessment. Refer to F 838.The facility had multiple system failures. Refer to F865.The facility failed to provide EBP for multiple devices, multiple residents, and failed to establish a legionella program. The facility further failed to prevent the spread of infection when staff walked down the hall with a glucometer machine, with a bloody strip in it, to dispose of it at the nurse's station. Refer to F 880.The facility failed to have a system in place to determine which residents were eligible for the Prevnar 20 vaccination. Refer to F883.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 70 residents. The sample included 18 residents. Based on record review and interviews, the facility failed to conduct a risk assessment to identify risks and implement a water management program to mitigate the risk of Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for 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 pneumonia caused by Legionella) and other waterborne pathogens. The facility failed to adhere to infection control procedures with wound care for Resident (R) 1 who had an open abdominal wound and a gastrostomy tube (G-tube surgically placed through an artificial opening into the stomach) and staff administered medications through the tube who had enhanced barrier precautions (EBP -an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and glove used during high contact resident care activities), failed to adhere to infection control procedures and failed to adhere to adhere to personal cares for R3, R20, and R35 who all had an indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag). The facility further failed to maintain infection control procedures when staff carried a bloody glucometer strip down the hallway versus dispensing it in the nearest sharps container.Findings included:- On 01/29/26 at 11:35 AM, Administrative Staff A verified the facility did not have a system to check for standing water in unoccupied rooms or to mitigate potential Legionella growth inside the facility. Administrative Staff A verified she was not aware of any routine facility water management checks, and they would have to initiate a program to complete the checks for Legionella's. The facility's Water Management Plan policy, dated 01/01/24, documented the facility would establish and maintain an infection prevention and control program designs to provide a safe, sanitary, and comfortable environment and help to prevent the development of and transmission of communicable disease. The policy documented the facility would establish a water management team, identify risks and implement control measures and control limits describing the water systems and flow diagrams. The flow charts would summarize the risks associated with the multiplication of the Legionella bacteria, given varying temperature ranges and common control points. Legionella grows best between 77 to 108 degrees Fahrenheit (scale of temperature on which water freezes at 32 degrees and boils at 212 degrees under standard conditions). The growth of Legionella bacteria is at risk where water is stagnant, and water flow is limited. As such, the use of flushing as a control measure is only for control points where flow is suspended for periods of time. Any determined on-going treatment and testing requirements determined by the management team would be recorded via a TELS task for that specific facility. The completion of TELS tasks is monitored by the water management team. The water Management Plan would be reviewed and updated as applicable annually, confirmed by the TELS task and annual Legionella training for the Maintenance Director. - On 01/27/26 at 08:30 AM, observation revealed Licensed Nurse (LN) G donned gloves and cleaned R1's wound on the right side of his abdomen with wound cleanser. Observation revealed greenish drainage, then LN G applied a 4 by 4 gauze pad and secured with border foam dressing. LN G discarded his gloves in a trash can in the resident's room. On 01/28/26 at 07:35 AM, observation revealed Certified Nurse Assistant (CNA) M and CNA N donned gloves and assisted R2 to reposition in bed and noted the resident has oxygen per nasal cannula and a Foley catheter bag attached to the right side of her bed. CNA M unclamped the catheter bag, wiped the spigot with an alcohol wipe,drained the urine in a plastic graduate,cleansed the spigot with an alcohol wipe, reattached the spigot in the bag,hooked it on the side of the bed then covered the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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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 - Some	urinary drainage bag with the protective cover, then emptied the graduate containing urine in the toilet. Observation revealed the CNAs wore gloves but lacked gowns or personal protective equipment with cares. CNA M and CNA N discarded their gloves in a trash can in the resident's room. On 01/28/26 at 08:55 AM, observation of LN G donned gloves and unhooked R1's feeding G-tube and administered 10 milliliters (ml) of water followed by liquid Tylenol (pain relief medication) 1000 milligrams (mg)/30 ml followed by and liquid Iron (iron supplement) 300 mg/5 ml medication then flushed with 10 ml of water, reattached the G-tube to the nutritional supplement -continuous feeding. LN G discarded his gloves in a trash can provided in the resident's room. On 01/28/26 at 01:05 PM, R44 laid in be on his back. LN G donned gloves and cleansed the left middle toe with wound cleanser, dried the area with a gauze sponge, then applied calcium alginate to the wound bed and secured with a band-aid. The left middle toe has a black area approximately 1/4 of an inch by 1/4 of an inch on the distal side of the toe with a small amount of serous (thin, clear) drainage, and the entire toe appears swollen and red. R44 complained of discomfort with the dressing change. LN G discarded his gloves in a trash can in the resident's room. Continued, observation revealed LN G cleansed the open area on R44's lateral left foot with wound cleanser. The wound appeared to be a one-half-inch round open area. LN G dried the area with a gauze sponge, then applied calcium alginate to the wound bed and secured it with bordered foam dressing. The open area had a small amount of serous drainage with redness around the open wound. LN G discarded his gloves in a trash can in the resident's room. On 01/29/25 at 01:05 PM, interview with Administrative Nurse E verified R21, R2, and R44 should be on EBP with signage on the door to the room with PPE supplies available for each resident care. Administrative Nurse E verified she would provide PPE for the residents who required it and inform staff of the proper care of the residents. The facility's Enhanced Barrier Precautions policy, dated 01/01/25, documented the facility would implement enhanced barrier precautions for the prevention of transmission of Multidrug-resistant organisms. The facility would train staff on hire of high-risk activities and common organisms that require EBP. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high contact care activities. An order for EBP would be obtained for the residents with the following: chronic wounds such as pressure ulcers diabetic foot ulcers, unhealed surgical wounds, chronic venous stasis ulcers, catheters, peripheral IV's insulin pumps, ostomies. The facility would have available gowns, and gloves immediately near or outside of the resident's room, and face protection may also be needed if performing activity with risk of splash or spray, PPE for EBP is only necessary when performing high contact care activities and may not need to be done prior to entering the resident's room. Ensure access to alcohol-based hand rub in every resident room and position a trash can inside the resident's room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. The Infection Preventionist would incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. Provide education to residents and visitors, High contact care areas include dressing, bathing, transferring, providing hygiene, changing linens changing briefs or assisting with toileting, device care or use of central lines, urinary catheters, feeding tubes, catheters, wound care and nay skin opening that required a dressing. Therapies should use gown and gloves when working with residents on EBP the therapy gym or in the resident's room if they anticipate prolonged, close body contact where MDRO transmission is possible. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident (R) 3 Electronic Medical Record (EMR) recorded diagnoses of adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), congestive heart failure (CHF -a condition with low heart output and the body becomes congested with fluid), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), severe protein-calorie malnutrition, lymphedema (swelling caused by accumulation of lymph), muscle weakness, unsteadiness on feet, 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). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documented had intact cognition, exhibited no behavioral symptoms, had a functional range of motion of both sides of the lower extremities, used a walker and wheelchair for mobility. R3 required substantial to maximal assistance with upper and lower body dressing, putting on and taking off footwear, bed mobility, sit to lying, lying to sitting, sit to standing, chair/bed to chair transfers, and walking ten feet. R3 had skin tears, nutritional/hydration interventions to manage skin problems, application of nonsurgical dressing, and application of ointment/medication other than to the feet. The MDS further documented that R3 received an antidepressant (a class of medications used to treat mood disorders), an anticoagulant (slows down the process of blood clotting), an antibiotic (a class of medications used to treat infections), and an opioid (medication used to treat pain). R3's Care Plan dated 07/13/25 documented R3 had an indwelling catheter related to BPH (BPH -non-cancerous enlargement of the prostate, which can lead to interference with urine flow, urinary frequency, and urinary tract infections), urinary retention. The Care Plan directed staff to position the catheter bag and tubing below the level of the bladder, change the catheter monthly, and monitor/record/report to the physician signs and symptoms of urinary tract infection (UTI -an infection in any part of the urinary system). The Physician Order dated 06/17/25 instructed staff to change the catheter and tubing monthly and as needed. The Physician Order also instructed R3 to be on Enhanced Barrier Precaution and must don personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) for all high contact care. The Practitioner Progress Note dated 01/27/26 at 09:50 AM documented that R3 was at high risk for UTI, recommended appropriate catheter care, and urine was yellow with sediment. The note also documented that R3 had a dressing on the left lower leg. On 01/29/26 at 09:05 AM, Licensed Nurse (LN) H provided left lower leg wound care. During the procedure, LN H wore gloves but did not wear a gown. LN H leaned over the bed while doing wound care with her uniform coming into contact with the catheter tubing. On 01/29/26 at 10:30 AM, Certified Nurse Aide (CNA) O and CNA P reported R3 declined the surveyors' request to observe catheter care. Both CNA O and CNA P verified that the room lacked EBP signage or had gowns stored in the room or outside the door. Both staff members also reported that they had not worn gowns when providing catheter care for the residents. On 01/29/25 at 02:24 PM, Administrative Nurse E verified R3's room lacked EBP signage, and that staff providing care of the catheter and wound should wear both gloves and gowns. Administrative Nurse E stated gowns should be stored inside and/or outside the room for direct care usage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Enhanced Barrier Precautions policy, dated 01/01/25, documents that it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. Implementation of EBPs: make gowns and gloves available immediately near or outside of the resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may need to be donned prior to entering the resident's room. Ensure access to alcohol-based hand rub in every resident room. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of room, or before providing care for another resident in the same room. - Resident (R) 20's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), 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), patient's noncompliance with other medical treatment and regimen, dementia (a progressive mental disorder characterized by failing memory and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), presence of urogenital implant (medical devices used to support or restore function in the urinary system), urinary tract infection (UTI -an infection in any part of the urinary system), and hydronephrosis (swelling of one or both kidneys, caused by back up of urine). R20's Annual Minimum Data Set (MDS) dated [DATE] documented that R20 had moderately impaired cognition, exhibited no behaviors, and had functional range of motion impairment of both lower extremities. R20 was dependent on staff for toileting, bathing, lower body dressing, and substantial/maximum assistance with bed mobility and transfers. R20 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and was always incontinent of bowel. The MDS further documented that R20 received insulin (a hormone that lowers the level of glucose in the blood) injections, an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), and antibiotic (a class of medications to treat infections). The Urinary Incontinence and Indwelling Care Area Assessment (CAA) dated 12/10/25 documented R20 had a diagnosis of neurogenic bladder and had a permanent catheter to dependent drainage. The catheter was changed monthly, and a history of urinary tract infections, and catheter care was performed totally by the staff. R20's Care Plan revised 12/14/25 documented R20 was at risk for urinary tract infection related to the indwelling catheter and neurogenic bladder. The Care Plan directed staff to evaluate urine characteristics, monitor for any changes in urine, and nursing may perform a urine dipstick if a UTI was suspected, and nursing to complete catheter care each shift. The Physician Order dated 01/06/26 directed staff that R20 was on Enhanced Barrier Precaution and staff must don personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and gloves) for all high contact care two times a day for the catheter. The Practitioner Progress Note dated 01/15/25 at 10:31 AM, documented R20 denied issues with his catheter or bowels, and that R20 had been back and forth from the emergency room (ER) multiple times over the last few months for catheter issues and infections. On 01/28/26 at 11:21 AM, R20 remained in bed. The bed was in a low position, and the catheter drainage bag was attached to the bed frame, which was not visible from the doorway. The urine in the tubing was yellow with sediment. On 01/29/26 at 10:30 AM, Certified Nurse Aide (CNA) O and CNA P reported R20 declined the surveyors' request to observe catheter care. Both CNA O and CNA P verified that the room lacked EBP signage or had gowns stored in the room or outside the door. Both staff members also reported that they did not wear gowns when providing catheter care for the residents. On 01/29/25 at 02:24 PM, Administrative Nurse E verified R20's room lacked EBP signage, and that staff providing care of the catheter and wound should wear both gloves and gowns. Administrative Nurse E stated gowns should be stored inside and/or outside the room for direct care usage. The facility's Enhanced Barrier Precautions policy, dated 01/01/25, documents that it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. Implementation of EBPs: make gowns and gloves available immediately near or outside of the resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may need to be donned prior to entering the resident's room. Ensure access to alcohol-based hand rub in every resident room. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of room, or before providing care for another resident in the same room. - R35's Electronic Medical Record (EMR) documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), 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), heart failure, acute kidney failure, and urinary tract infection (UTI -an infection in any part of the urinary system). R35's 5-Day Minimum Data Set (MDS) dated [DATE] documented R35 had intact cognition, functional range of motion impairment of both lower extremities, was dependent on staff for toileting, bathing, upper and lower body dressing, bed mobility, and transfers. R35 had an indwelling catheter and was always incontinent of bowel. The MDS further documented that R35 had insulin (a hormone that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lowers the level of glucose in the blood) injections, received an antidepressant (a class of medications used to treat mood disorders), an antibiotic (a class of medications used to treat infections), a diuretic (a medication to promote the formation and excretion of urine), and an opioid (medication used to treat pain). R35's Care Plan, revised 08/23/25, documented that R35 had an indwelling catheter due to a neurogenic bladder. The Care Plan directed staff to change the catheter monthly, monitor/record/report to the physician signs and symptoms of a UTI, and provide catheter care every shift. The Physician Order dated 08/29/25 directed staff to change the catheter monthly. The Physician Orders did not contain directions for Enhanced Barrier Precaution (EBP) personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) for all high contact care two times a day for the catheter. The Progress Note dated 01/18/26 at 05:40 AM documented a change in condition of abdominal pain and altered mental status. The note further documented that the primary care provider recommended R35 to be sent to the hospital. The Progress Note dated 01/22/26 at 04:00 PM documented that R35 had returned to the facility, had a UTI, and was on an antibiotic. On 01/28/26 at 11:22 AM, R35 was in bed. R35 was alert and reported she had recently been in the hospital for a UTI and was taking an antibiotic. R35 reported that the staff took care of all her catheter care. The catheter bag was attached to the bed frame and not visible from the doorway. On 01/29/26 at 11:00 AM, Certified Nurse Aide (CNA) Q verified R35's room lacked signage for EBP, and she had not worn a gown while caring for the catheter. On 01/29/25 at 02:24 PM, Administrative Nurse E verified R35's room lacked EBP signage, and that staff providing care of the catheter and wound should wear both gloves and gowns. Administrative Nurse E stated gowns should be stored inside and/or outside the room for direct care usage. The facility's Enhanced Barrier Precautions policy, dated 01/01/25, documents that it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. Implementation of EBPs: make gowns and gloves available immediately near or outside of the resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may need to be donned prior to entering the resident's room. Ensure access to alcohol-based hand rub in every resident room. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of room, or before providing care for another resident in the same room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 01/27/26 at 04:00 PM, observation revealed Licensed Nurse (LN) G exited R8's room, carrying a glucometer machine with a bloody strip in it. LN G went down the hall to the nurse's cart and discarded it in a sharps container on the cart. On 01/27/26 at 04:26 PM, LN G verified he had walked down the hall, carried a glucometer machine with a bloody strip in it, and stated he probably should have brought the cart down the hall outside R8's room. On 01/28/26 at 08:45 AM, Administrative Nurse D stated staff should dispose of a glucometer strip with blood on it in a resident's room in a sharps container. The facility's Infection Prevention and Control Program, revised 01/01/25, documented that the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary environment, and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 70 residents. The sample included 18 residents, with five residents reviewed for immunizations, Resident (R) 16, R31, R43, R55, and R56, to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer, obtain an informed declination, or a physician documented contraindication for the pneumococcal PCV20 vaccination per the latest guidance from the Centers for Disease Control and Prevention (CDC).Findings included:- Review of the clinical medical records lacked evidence the facility or the resident representative received or signed a consent to receive or informed declination for the pneumococcal vaccine PCV20 for the following residents.Review of R16's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE]. R16 had not been offered or received a pneumococcal PCV20 vaccine since admission.Review of R31's EMR revealed the resident was admitted to the facility on [DATE]. R31 had not been offered or received a pneumococcal PCV20 vaccine since admission.Review of R43's EMR revealed the resident was admitted to the facility on [DATE]. R43 had not been offered or received a pneumococcal PVC20 vaccine since admission.Review of R55's EMR revealed the resident was admitted to the facility on [DATE]. R55 had not been offered or received a pneumococcal PCV20vaccine since admission.Review of R56's EMR revealed the resident was admitted to the facility on [DATE]. R56 had not been offered or received a pneumococcal PCV20 vaccine since admission.On 01/28/26 at 11:00 AM, Administrative Nurse E stated residents were offered the pneumonia vaccines on admission and as indicated. Administrative Nurse E said the resident or resident representative would sign a consent or declination for receiving the vaccine. Administrative Nurse E verified that every resident in the building had not been reviewed to determine if they were eligible to receive the PVC20 vaccine or not. Administrative Nurse E verified they did not have a definitive system in place to determine who was eligible, or if they were eligible, if they had been offered or declined the vaccinations, and verified this was something they had recently been working on.The facility's Pneumococcal Vaccine policy, dated 10/01/25, documented each resident would be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional effort to obtain information shall be documented, including efforts to determine the date of immunization or the type of vaccine received. Each resident would be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. The resident or the resident's representative retains the right to refuse the immunization. The facility would document in the clinical record the reason for refusal or the medical contraindication of the immunization. The consent shall be signed prior to the administration of the vaccine and filed in the individual's medical record. The type of pneumococcal vaccine (PCV15, PCV20, PCV21, or PPSV23) would be offered depending on the residents' age, having certain risk conditions, and previously received pneumococcal vaccines, in advance according to current CDC guidelines and recommendations.

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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. The facility had a census of 70 residents. The sample included 18 residents, with three residents reviewed for discharge. Based on observation, record review, and interview, the facility failed to provide Resident (R) 20 and R2 with written information regarding the facility's bed hold policy when the residents were transferred to the hospital and failed to notify the State Long Term Care Ombudsman (LTCO) of their facility-initiated discharge to the hospital.Findings include: - Resident (R) 20's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), 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), patient's noncompliance with other medical treatment and regimen, dementia (a progressive mental disorder characterized by failing memory and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), presence of urogenital implant (medical devices used to support or restore function in the urinary system), urinary tract infection (UTI -an infection in any part of the urinary system), and hydronephrosis (swelling of one or both kidneys, caused by back up of urine). R20's Minimum Data Set (MDS) recorded: On 07/02/25, a Discharge Return Anticipated. On 07/07/25, an Entry into the facility. On 07/17/25, a Discharge Return Anticipated. On 07/22/25, an Entry into the facility. On 10/27/25, a Discharge Return Anticipated. On 10/30/25, an Entry into the facility. On 11/29/25, a Discharge Return Anticipated. On 12/03/25, an Entry into the facility. The Progress Note dated 07/02/25 at 08:11 AM, documented R20 had a change in condition, responsive and talking, and initially combative and resistant to care. R20 refused oxygen saturation, blood glucose check, and the administration of insulin (a hormone that lowers the level of glucose in the blood). R20 had light green emesis (vomit) with food particles and ongoing gurgling. Staff attempted to assist R20 multiple times, but was limited due to aggression and attempts to hit and kick staff. The note further documented a blood sugar reading of 333, oxygen saturation of 92 percent (%), and a temperature of 104.8 Fahrenheit (F). Staff called 911 at 12:24 AM, and upon arrival, R20 had projectile vomiting, oxygen saturation dropped to 74%, and oxygen was applied. R20 was sent to the hospital. Staff obtained the physician's order to send to the hospital, and R20's family member was notified. The note lacked mention of whether bed hold consent had been given or obtained. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 07/15/25 at 08:24 AM documented that R20 had increased penile pain. The area was assessed and intact, with the lack of a catheter secure (device to anchor the catheter to the leg), as R20 would often remove it. The catheter secure was placed, and barrier cream was applied. The catheter remained in place and was draining cloudy yellow urine. R20 was educated on the importance of not pulling on the catheter and leaving the catheter secure in place. This note was the last entry. The MDS recorded a Discharge Return Anticipated on 07/17/25. The Progress Notes lacked R20's discharge assessment or mention of a bed hold to R20 or R20's representative notification. The Progress Note dated 07/22/25 at 03:52 PM documented R20 returned to the facility on a stretcher with two attendants. R20's had stable and within normal vital signs. R20 was to receive an antibiotic (a classification of medication used to treat infections) through a peripheral line (a short, flexible tube inserted into a small vein to deliver fluids and medications into the bloodstream) in the left forearm. The Progress Note dated 10/27/25 at 09:00 AM documented a change of condition with abnormal vital signs for R20. The note documented R20 had an altered mental status decline, shortness of breath, was tired, weak, and confused. The primary care provider was notified of the condition and responded by sending R20 to the hospital for possible sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body). The Progress Notes lacked R20's discharge assessment or mention of a bed hold to R20 or R20's representative notification. The Progress Note dated 11/29/25 at 04:56 PM documented R20 had increasing confusion, needed additional assistance with activities of daily living, had cloudy urine with sediment, and a non-productive cough. R20's representative was at the bedside and requested that R20 be sent to the emergency room for evaluation. The Progress Notes lacked R20's discharge assessment or mention of a bed hold to R20 or R20's representative notification. The Progress Note dated 12/03/25 at 05:17 PM documented that R20 had returned to the facility. On 01/28/26 at 12:14 PM, R20 was in the dining room and was assisted to eat his meal. R20's hair was not combed, and R20 had facial hair stubble on his face. On 01/28/26 at 01:38 PM, upon review of the Ombudsman's monthly notification list, the review revealed R20 had not been included in the discharge notifications. Social Service X reported the discharge list pulled from the facility's computerized system did not include R20's discharges and, therefore, was not sent to the Ombudsman. On 01/28/26 at 01:04 PM, Administrative Staff A reported the facility could not locate the bed holds for R20's discharges to the hospital. Administrative Staff A stated the nursing staff who discharged residents to the hospital was responsible for getting the resident or representative the bed hold paperwork. The facility's Bed Hold Notice policy, dated 04/01/25, documents that it is the policy of the facility to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance and at the time of a transfer for hospitalization or therapeutic leave. The facility's undated Transfer and Discharge policy documented that it is the policy of the facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. The facility will maintain evidence that the notice was sent to the Ombudsman. Emergency transfers to acute care, the Social Service Director, or designee, would provide copies of notice for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. - R2's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), chronic kidney disease Stage 3 (kidneys are moderately damaged and filter waste and fluid less effectively), dysphagia (swallowing difficulty), and chronic obstructive pulmonary disease (COPD -a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Nurse's Note dated 08/25/25 at 10:50 PM documented an order was received to send R2 to the emergency room, and she left the faciity on a stretcher due to retching (the sound and movement of vomiting) with black/brown emesis. The Nurse's Note dated 09/03/25 at 01:27 PM documented the resident arrived at the facility per emergency medical transport. R2's clinical record lacked a bed hold policy and a resident or resident representative signature. R2's clinical record lacked documentation staff notified the LTCO of R2's discharge from the facility to the hospital. On 01/29/26 at 1:00 PM, Administrative Staff A verified the facility was unable to provide written evidence upon request. They had a bed hold policy for R2 and stated the nurse who discharges the resident should have the resident or family sign the bed hold policy. On 01/29/26 at 01:38 PM, Social Service X verified the facility lacked evidence that the LTCO was notified of R2's discharge to the hospital. Social Service X verified she sent monthly discharged resident information to the LTCO office, but R2 was not included in the monthly report. The facility's Bed Hold Notice policy, dated 01/28/26, documented the facility would provide written information to the resident and/or the resident's representative regarding bed hold practices both well in advance and at the time of transfer for hospitalization and therapeutic leave. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility would provide the resident and/or the resident's representative with written information that specifies: The duration of the State bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. The reserve bed hold payment policy in the state plan policy, if any. The facility policies regarding bed-hold periods include allowing a resident to return to the next (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available bed. Conditions upon which the residents would return to the facility. The resident required the services which the facility provides The resident was eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. In the event of an emergency transfer of a resident, the facility would provide written notice of the facility's bed hold policies to the resident and/or the resident's representative within 24 hours. The facility would document multiple attempts to reach the resident's representative within 24 hours. The facility would document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility would keep a signed and dated copy of the bed hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. The facility's Ombudsman and State Agency Notices policy, undated, documented to ensure residents, residents' representatives, visitors, and staff have clear, continuous access to information regarding resident rights, advocacy services, and complaint processes through the proper posting of required notices, in accordance with federal and state requirements. The posting of the office of the Ombudsman included notice of Transfers and Discharge rights related to transfer, discharge, and requirements that copies of transfer/discharge notices are provided to the Ombudsman.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 70 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to identify and implement interventions to prevent further injuries to the lower extremities of Resident (R) 3 and R44's smoking activity.Findings included:- R3's Electronic Medical Record (EMR) recorded diagnoses of adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), congestive heart failure (CHF -a condition with low heart output and the body becomes congested with fluid), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), severe protein-calorie malnutrition, lymphedema (swelling caused by accumulation of lymph), muscle weakness, unsteadiness on feet, 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). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documented R3 had intact cognition, exhibited no behavioral symptoms, had a functional range of motion of both sides of the lower extremities, and used a walker and wheelchair for mobility. R3 required substantial to maximal assistance with upper and lower body dressing, putting on and taking off footwear, bed mobility, sit to lying, lying to sitting, sit to standing, chair/bed to chair transfers, and walking ten feet. R3 had skin tears, nutritional/hydration interventions to manage skin problems, application of nonsurgical dressing, and application of ointment/medication other than to the feet. The MDS further documented that R3 received an antidepressant (a class of medications used to treat mood disorders), an anticoagulant (a class of medication used to thin blood), an antibiotic (a class of medications used to treat infections), and an opioid (a medication used to treat pain). R3's Care Plan dated 05/13/25 documented R3 had a potential for impaired skin integrity related to impaired mobility and incontinence. The Care Plan directed staff to assess and record changes in skin status. R3's needed for substantial assistance from one to two staff with turning/repositioning, and nursing would complete a weekly skin assessment and would monitor skin with all care. The Care Plan also documented that R3 had an activity of daily living (ADL) performance deficit related to Parkinson's disease and spinal stenosis, and required extensive assistance of one to two staff with transfers using the stand pivot method. The Care Plan lacked interventions to prevent injuries to R3's lower extremities from a laceration obtained from the bedframe during a transfer on 11/13/25. The Physician Order dated 01/05/26 directed staff to cleanse the left lateral (pertaining to the side, away from the middle) calf with normal saline (NS -saline water solution for medical use), pad dry with gauze, wet kerlix (stretchy gauze bandage) with normal saline, pack wound, cover with non-adherent pad, cover with abdominal pad, then wrap with Coban (a self-adhesion wrap) once a day. The Progress Note dated 11/14/25 at 03:09 AM documented that the nurse and nurse manager assessed R3's wound. The wound had blood on Kerlix. The Kerlix was removed, and sutures were intact; a nonadherent dressing and Kerlix were applied. The Progress notes before 11/14/25 lacked any mention of wound cause or incident related to the wound. The Progress Note dated 11/14/25 at 04:16 AM documented that the nurse assessed R3's left leg wound. The dressing was clean and intact. No issues with the dressing at that time. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Infection Type Progress Note dated 11/17/25 at 05:11 PM documented fungal/skin infection (unspecific) receiving antibiotic therapy for wound infection to the left lower leg, cefpodoxime 200 milligrams (mg) by mouth two times a day. The resident returned to the facility with 17 sutures due to a leg laceration. Prophylactic (prevention) antibiotics began due to an extensive wound. On 01/29/26 at 08:21 AM, R3 stated the leg wound happened when a Certified Nurse Aide (CNA) was assisting him to bed for the night. R3 stated that his leg hit something on the bed frame. He was sent to the ER and received 17 stitches, with a measurement of five inches long. On 01/29/26 at 09:05 AM, Licensed Nurse (LN) H reported she was unsure of what caused the laceration, stating she was a new employee to the facility. On 01/29/26 at 02:45 PM, Administrative Nurse E reported she and the head of the housekeeping department looked at the bedframe and wheelchair and could not locate any sharp edges that would have caused the laceration. Administered Nurse E verified that the care plan lacked interventions to prevent further injury. The facility's Comprehensive Care Plan policy, dated 01/01/25, documented it was the policy of the facility to develop and implement a comprehensive person-center care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, an mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and professional standards of quality. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Qualified staff responsible for carrying out interventions specific to the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. - R44's diagnoses included metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), fracture right femur (thigh bone), pneumonia (a lung infection that causes inflammation and fluid or pus to fill the air sacs of the lungs), and nicotine dependency. R44's admission Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R44 was dependent on staff with activities of daily living (ADL), used a wheelchair for mobility, and required staff supervision in the facility. The MDS documented R44 did not use tobacco. R44's Activities of Daily Living Care Area Assessment (CAA) dated 12/22/25 documented the resident required substantial assistance with toileting, bathing, dressing, bed mobility, and transfers. The CAA documented that the resident was non-ambulatory and used a wheelchair for all mobility and used a stand pivot transfer. The CAA documented that the resident was alert and oriented. R44's Care Plan, dated 12/28/25, directed staff to assist R44 with a stand pivot transfer. The care plan recorded R44 used a wheelchair and did not ambulate. R44 lacked a smoking Care Plan. R44's Smoking Safety Risk Assessment, dated 12/22/25, documented R44 did not currently smoke or (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use electronic smoking devices. On 01/06/26, Encounter Notes documented R44 smoked half a pack of cigarettes a day. On 01/28/26 at 08:35 AM, observation revealed R44 seated on the side of his bed, and Certified Medication Aide R administered R44's morning medications. On 01/27/26 at 04:05 PM, Administrative Staff A verified R44 was admitted to the facility, and a Safe Smoking Assessment was completed, but failed to document that the resident did smoke. Administrative Staff A verified the staff should have filled out the smoking assessment to see if the resident was able to smoke safely or what was required to assist him to smoke safely. Administrative Staff A stated the staff would complete a Smoking Assessment for R44 soon. The Smoking Assessment policy, dated 01/02/26, documented that the facility would promote resident-centered care by providing a safe smoking area for the residents who request to smoke and are capable of safe smoking behaviors either independently or with supervision, unless the facility is a designated nonsmoking facility. The policy documented e-cigarettes and vaporizers would be treated as a traditional cigarette, and residents would be assessed by the interdisciplinary team (IDT) and designated as dependent or independent. The policy documented smoking assessments for the residents who requested to smoke would be completed on admission, quarterly, and with any change in condition. Assessment for independent or supervised smoking would be determined by the IDT team to assess the level of cognition for safe smoking, the level of dexterity to manage smoking and smoking materials, assessment of ability to understand and comply with the policy, and assessment of ability to smoke safely. Smokers would be permitted to smoke only in designated smoking areas on the South patio, and outside smoking may be prohibited by the Executive Director if weather conditions are determined to be a risk to resident safety. Facility staff would secure smoking materials in a locked area when not in use by the residents for both independent and supervised smokers. The facility would document resident and family education in the medical records for acknowledgement of the Resident Smoking policy. The Comprehensive Care Plan policy, dated 01/01/25, documented the facility would develop and implement a comprehensive care plan for each resident consistent with resident rights, which includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The care planning process would include an assessment of the resident's strengths, needs, and would incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality and incorporate culturally competent and trauma-informed care as indicated. The comprehensive care plan would be developed within 7 days after completion of the comprehensive MDS assessment. All CAAS triggered by the MDS would be considered in developing the care plan. Other factors identified by the IDT, or in accordance with the resident's preferences, would also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning would be evidenced in the clinical record. The comprehensive care plan would describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. The comprehensive care plan would be reviewed and revised by the IDT after each comprehensive and quarterly MDS.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 70 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility staff failed to provide necessary services for two of six residents reviewed for activities of daily living (ADL): Resident (R) 69 and R20.Findings included:- R69's Electronic Medical Record (EMR) documented R69 had diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) and sequelae of cerebral infarction (commonly known as a stroke, when blood flow to the brain is blocked or a blood vessel inside or on the surface of the brain bursts). R69's Quarterly Minimum Data Set (MDS) dated [DATE] documented R69 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented R69 required substantial, maximal staff assistance with showering. R69's Care Plan, revised 12/25/25, documented R69 required substantial staff assistance with bathing and instructed staff to provide a sponge bath when a full bath or shower could not be tolerated by R69. The Skin Monitoring Comprehensive CNA Shower Review Sheets revealed R69 had a bath on the following dates: November 2025- 0. December 2025- refused on 12 and 21. January 2026- 4, 8, and 18. R69s' clinical record did not specify the dates the resident was scheduled to have a bath. On 01/29/25 at 03:00 PM, Administrative Nurse E stated that if a resident refused a bath, staff should document it on the skin monitoring sheet. Administrative Nurse E stated that staff should document on the skin monitoring sheet when a resident receives a bath, and if they have not received one after two days of their scheduled bathing day, the nurse should be notified. Administrative Nurse E stated that if the resident refused, the staff were to offer different methods for bathing, like bed baths and bathing wipes. The facility's Resident Showers Policy, revised, documented it was the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice. Residents would be provided with showers as per request or as per facility schedule protocols and based upon safety. - R20's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), 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), patient's noncompliance with other medical treatment and regimen, dementia (a progressive mental disorder characterized by failing memory and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), presence of urogenital implant (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(medical devices used to support or restore function in the urinary system), urinary tract infection (UTI -an infection in any part of the urinary system), and hydronephrosis (swelling of one or both kidneys, caused by back up of urine). R20's Annual Minimum Data Sheet (MDS) dated [DATE] documented that R20 had moderately impaired cognition and exhibited no behaviors. R20 was dependent on staff for toileting, bathing, and lower-body dressing. The MDS further documented that R20 had an indwelling catheter and was always incontinent of bowel. R20's Functional Abilities Care Area Assessment (CAA) dated 12/10/25 documented that R20 had multiple comorbidities, neurogenic bladder, frequent UTI, and frequent hospitalizations. The CAA further documented that R20 required total assistance from one to two staff for toileting and bathing. R20's Care Plan, revised 12/14/25, documented that R20 had a functional ability deficit related to impaired balance, generalized weakness, and a history of a 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 cognitive impairment. The Care Plan documented R20 required extensive assistance with bathing, and if he was resistant with ADLs, to reassure the resident, leave and return in five to ten minutes, and try again. Upon review of the bathing task and Shower and Skin Monitoring sheets from 10/31/25 to 01/28/26, revealed that R20 had received eight showers out of 23 opportunities. This review revealed R20 received two showers in 11/2025 and 12/2025, and four showers in 01/2026. On 01/28/26 at 12:14 PM, R20 was sitting in the dining room, being assisted by staff to eat. R20's hair was not combed, and he had facial hair from several days' growth. On 01/29/25 at 03:00 PM, Administrative Nurse E stated that if a resident refused a bath, staff should document it on the skin monitoring sheet. Administrative Nurse E stated that staff should document on the skin monitoring sheet when a resident receives a bath, and if they have not received one after two days of their scheduled bathing day, the nurse should be notified. Administrative Nurse E stated that if the resident refused, the staff were to offer different methods for bathing, like bed baths and bathing wipes. The facility's undated Resident Showers Policy documented that it was the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice. Residents would be provided with showers as per request or as per facility schedule protocols and based upon safety.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 70 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility staff failed to provide care and treatment in accordance with professional standards of practice when the staff failed to provide Resident (R) 6 treatment for low blood sugar before transferring to the hospital. The facility failed to provide documentation related to R3's and R20's transfer to the hospital. Findings included:- R6's Electronic Medical Record, (EMR) documented R6 had a diagnosis of Type 2 Diabetes Mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R6's Quarterly Minimum Data Set (MDS) dated [DATE] documented R6 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. The MDS documented that R6 received insulin (a hormone that lowers the level of glucose in the blood) for seven days during the look-back period. R6's Care Plan revised 12/25/25 documented R6 had Diabetes Mellitus and instructed staff to monitor him for signs or symptoms of hypoglycemia (less than normal amount of sugar in the blood). Review of R6's October Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed a lack of documentation that the facility staff administered glucagon (a medication to treat severe hypoglycemia) to R6 on 10/28/25 at the time of the incident. R6's Clinical Record lacked a progress note with documentation regarding the incident on 10/28/25. The Emergency Medical Technician (EMT) Report, dated 10/28/25 at 05:18 AM, documented that the EMT arrived at the facility to find R6 lying semi-Fowler's (a standard patient position in which the patient is seated in a semi-sitting position (45–60 degrees) and may have knees either bent or straight) in bed, eyes closed. A physical assessment was conducted. R6 was physically responsive to pain but not verbally responsive. EMT checked R6's blood sugar level (the amount of simple sugar moving through your body at any given time), and it was 31. The facility staff were frantically fanning R6, agitated, and immediately demanded that the EMT staff administer glucagon. EMT replied by protocol that they would try for an intravenous (IV-administered directly into the bloodstream via a vein) first for D10 (normal saline (10% dextrose in normal saline providing 10 grams of dextrose per 100 mL along with 0.9% sodium chloride) administration. The report documented that EMT was unsuccessful with the attempt for IV establishment, so they prepared glucagon and administered it in R6's right anterolateral thigh, and R6's blood glucose went up to 45. The facility staff reported that when they went into R6's room this morning, his eyes were open, and he was breathing but was unresponsive. The report documented staff stated she did not check his oxygen saturation, but she placed him on 3 liters of oxygen. The report documented that facility staff stated R6's normal was not normally on oxygen, but she felt airway was key. The facility staff stated she checked R6's blood sugar, and it was 31. The facility staff stated she gave him glucose gel, but could not give a specific dose. The facility staff member stated that she knew R6 took insulin (a hormone that lowers the level of glucose in the blood) and got his regular dose, but did not know how much or when, other than that it was the previous night. The facility staff did not know if R6 had taken it with a meal or when he last ate. The facility staff stated that tonight was her first time working at the facility, and she did not know much about R6 or his baseline presentation. On 01/27/26 at 03:20 PM, observation revealed R6 rested in bed with eyes open and visited politely (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with staff. On 01/27/26 at 11:23 AM, Certified Nurse Aide (CNA) MM stated she was working the night shift on the 400 hall on the south side of the facility on 10/28/25. CNA MM stated R6's blood sugar plummeted to the 30's (according to Medicine Net.com, normal blood sugar levels range from 70-130). CNA MM stated Licensed Nurse (LN) J could not find the glucose shot. Emergency Medical Service (EMS) came to the facility, and R6 was transferred to the hospital by ambulance. On 01/27/26 at 11:27 AM, LN I stated she had no recollection regarding R6's transfer to the hospital on [DATE]. LN I stated she did know R6 was a brittle diabetic, and at some point, R6 had been transferred to the hospital for low blood sugar. On 01/28/26 at 01:40 PM, Administrative Nurse E stated she would expect staff to administer glucose gel when R6's blood glucose dropped into the 30's. Administrative Nurse E stated the glucose gel is kept in the nurse medication cart, and R6 also had one in the Pyxis machine (an automated medication dispensing system that securely stores, manages, and tracks medications at the point of care). The facility's Blood Glucose Monitoring Policy, revised 2023, documented that the policy of the facility was to perform blood glucose monitoring for diabetic residents as the physician ordered. - R3's Electronic Medical Record (EMR) recorded diagnoses of adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), congestive heart failure (CHF -a condition with low heart output and the body becomes congested with fluid), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), severe protein-calorie malnutrition, lymphedema (swelling caused by accumulation of lymph), muscle weakness, unsteadiness on feet, 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). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documented R3 had intact cognition, exhibited no behavioral symptoms, had a functional range of motion of both sides of the lower extremities, used a walker and wheelchair for mobility. R3 required substantial to maximal assistance with upper and lower body dressing, putting on and taking off footwear, bed mobility, sit to lying, lying to sitting, sitting to standing, chair/bed to chair transfers, and walking ten feet. R3 had skin tears, nutritional/hydration interventions to manage skin problems, application of nonsurgical dressing, and application of ointment/medication other than to the feet. The MDS further documented that R3 received an antidepressant (a class of medications used to treat mood disorders), an anticoagulant (slows down the process of blood clotting), an antibiotic (a class of medications used to treat infections), and an opioid (medication used to treat pain). R3's Care Plan dated 05/13/25 documented R3 had a potential for impaired skin integrity related to impaired mobility and incontinence. The Care Plan directed staff to assess and record changes in skin status. R3's needed for substantial assistance from one to two staff with turning/repositioning, and nursing would complete a weekly skin assessment and would monitor skin with all care. The Care Plan also documented that R3 had an Activity of Daily Living (ADL) performance deficit related to Parkinson's disease and spinal stenosis and required extensive assistance of one to two staff with transfers using the stand pivot method. The Care Plan lacked interventions to prevent injuries to R3's lower extremities from a laceration obtained from the bedframe during a transfer on 11/13/25. (continued on next page)

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	175215	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tonganoxie Terrace	1010 East Street Tonganoxie, KS 66086

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 01/05/26 directed staff to cleanse the left lateral (pertaining to the side, away from the middle) calf with normal saline (NS -saline water solution for medical use), pad dry with gauze, wet kerlix (stretchy gauze bandage) with normal saline, pack wound, cover with non-adherent pad, cover with abdominal pad, then wrap with Coban (a self-adhesion wrap) once a day. The Progress Note dated 11/14/25 at 03:09 AM documented that the nurse and nurse manager assessed R3's wound. The wound had blood on Kerlix. The Kerlix was removed, and sutures were intact; a nonadherent dressing and Kerlix were applied. The Progress notes before 11/14/25 lacked any mention of the wound cause or incident related to the wound. The Progress Note dated 11/14/25 at 04:16 AM documented that the nurse assessed R3's left leg wound. The dressing was clean and intact. No issues with the dressing at that time. The medical record lacked a nursing assessment of R3's condition before being sent to the hospital for evaluation on 11/13/25. The Infection Type Progress Note dated 11/17/25 at 05:11 PM documented fungal/skin infection (unspecific) receiving antibiotic therapy for wound infection to the left lower leg, cefpodoxime (an antibiotic) 200 milligrams (mgs) by mouth two times a day. The resident returned to the facility with 17 sutures due to a leg laceration. Prophylactic (prevention) antibiotics began due to an extensive wound. The Practitioner Acute Follow Up Progress Note dated 11/18/25 documented the nature of the presenting problem on laceration. The resident was seen today at the request of nursing for increased swelling and redness to the lower left extremity and had an emergency room (ER) visit and sutures placed. The resident reported that the laceration occurred last week, but the chart shows the laceration on 11/13/25. R3 reported pain in the leg since, but no increase in pain. Nursing present reported they were not sure if the swelling or redness was new or not. The resident was started on Keflex (an antibiotic) at the ER when the sutures were placed, to cover for Methicillin-resistant Staphylococcus aureus (MRSA -a type of bacteria resistant to many antibiotics), and would start Bactrim (an antibiotic) twice a day, and the resident agreed with the plan. The plan for the laceration with foreign body, left lower leg on 11/13/25, when R3 was initially sent to ER and had 17 sutures placed and started on Keflex with warmth/swelling and fluctuating mass, unclear if abscess (cavity containing pus and surrounded by inflamed tissue) or hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma), although it seems to more likely represent hematoma, will add Bactrim twice a day for seven days. The Progress Note dated 11/19/25 at 08:45 PM documented that R3 had returned from the hospital at 08:26 PM. R3 had been sent out for provider evaluation of a laceration to the left lateral calf. Upon return, R3 had new orders for cephalexin (an antibiotic) and doxycycline (an antibiotic). R3 was diagnosed with cellulitis (skin infection caused by bacteria). The previous Bactrim was placed on hold, and further clarification was needed regarding the antibiotic regimen. The medical record lacked a nursing assessment of R3's condition prior to being sent to the hospital for evaluation. On 01/29/26 at 08:21 AM, R3 stated the leg wound happened when a Certified Nurse Aide (CNA) was assisting him to bed for the night. R3 stated that his leg hit something on the bed frame. He was sent to the ER and received 17 stitches, with a measurement of five inches long. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/26 at 09:05 AM, Licensed Nurse (LN) H provided wound care to R3's lower legs. The left leg laceration had a thin scab line of five inches in length. LN H utilized gloves but did not wear a gown throughout the procedure. LN H reported she was unsure of what caused the laceration, stating she was a new employee to the facility. On 01/29/26 at 02:45 PM, Administrative Nurse E reported that the nurse should complete a narrative of the resident's condition related to the need to be sent to the ER or hospital. The facility's undated Comprehensive Nursing Assessment Policy documented that the facility shall complete a comprehensive nursing assessment for every resident upon admission, upon return from a hospital stay, upon a significant change in physical or mental condition, and upon discharge, as part of the required recapitulation of stay and discharge documentation. Assessments shall be completed by a licensed nurse, documented in the medical record, and used to inform care planning, physician notification, and interdisciplinary interventions. Discharge assessments shall be documented using the facility's form and shall reflect the resident's status at the time of discharge. Failure to complete or document assessment in accordance with this policy may result in corrective action and may place the facility at risk for regulatory noncompliance. - R20's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), 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), patient's noncompliance with other medical treatment and regimen, dementia (a progressive mental disorder characterized by failing memory and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), presence of urogenital implant (medical devices used to support or restore function in the urinary system), urinary tract infection (UTI -an infection in any part of the urinary system), and hydronephrosis (swelling of one or both kidneys, caused by back up of urine). The Progress Note dated 07/15/25 at 08:24 AM documented that R20 had increased penile pain. The area was assessed and intact, with the lack of a catheter secure (device to anchor the catheter to the leg), as R20 would often remove it. The catheter secure was placed, and barrier cream was applied. The catheter remained in place and was draining cloudy yellow urine. R20 was educated on the importance of not pulling on the catheter and leaving the catheter secure in place. This note was the last entry. The MDS recorded a Discharge Return Anticipated on 07/17/25. The Progress Notes lacked R20's discharge assessment. The medical record lacked a nursing assessment of R20's condition before being sent to the hospital for evaluation. The Progress Note dated 07/22/25 at 03:52 PM documented R20 returned to the facility on a stretcher with two attendants. R20's had stable and within normal vital signs. R20 was to receive an antibiotic (a classification of medication used to treat infections) through a peripheral line (a short, flexible tube inserted into a small vein to deliver fluids and medications into the bloodstream) in the left forearm. On 01/28/26 at 12:14 PM, R20 was in the dining room and being assisted with eating his meal. R20's hair was not combed, and R20 had facial hair stubble on his face. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/26 at 02:45 PM, Administrative Nurse E reported that the nurse should complete a narrative of the resident's condition related to the need to be sent to the emergency room or hospital. The facility's undated Comprehensive Nursing Assessment Policy documented that the facility shall complete a comprehensive nursing assessment for every resident upon admission, upon return from a hospital stay, upon a significant change in physical or mental condition, and upon discharge, as part of the required recapitulation of stay and discharge documentation. Assessments shall be completed by a licensed nurse, documented in the medical record, and used to inform care planning, physician notification, and interdisciplinary interventions. Discharge assessments shall be documented using the facility's form and shall reflect the resident's status at the time of discharge. Failure to complete or document assessment in accordance with this policy may result in corrective action and may place the facility at risk for regulatory noncompliance.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 70 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to fully investigate Resident (R) 25's unwitnessed fall to identify causative factors and implement interventions to prevent further falls. The facility further failed to accurately identify R44's tobacco use and assess his ability to safely smoke independently. Findings included: - R25's Electronic Medical Record (EMR) documented the resident had diagnoses Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), hypoxia (inadequate supply of oxygen), hypertension (HTN -elevated blood pressure), and muscle weakness. R25's admission Minimum Data Set (MDS) dated [DATE] recorded the resident had a Brief Interview for Mental Status (BIMS) of 00, indicating severely impaired cognition. The MDS recorded the resident was dependent on staff for most activities of daily living (ADL). The MDS recorded R25 required substantial to maximum staff assistance with all transfers and used a wheelchair for mobility. R25's Care Plan dated 01/07/26 documented the resident had a history of falls, was a high risk for falls, had cognitive impairment, poor safety awareness, and wandering behaviors. The care plan directed staff to meet the residents' needs, be sure the call light was within reach, the bed was in the lowest position, and when in a wheelchair, be sure the brakes are locked. The care plan documented staff would have the resident wear shoes or nonskid socks. The staff would attempt to determine the cause of falls, record the root cause, and remove any potential cause.The Nurses Note dated 01/25/26 at 04:00 PM documented R25 had a fall in her room. A Certified Nurse's Aide (CNA) had just been in R25's room and changed her brief, and the resident was in bed and covered up to rest. A few minutes later the aide notified the nurse R25 got out of bed, (which was not typical for the resident). The nurse documented when the resident fell and it appeared she hit her head most likely on her roommate's wheelchair. Observation revealed R25 had a laceration to the left-center of forehead and was bleeding. The Licensed Nurse (LN) and CNA got R25 off the floor and transferred her to bed and immediately obtained her vital signs. The LN cleansed the forehead wound and placed a dressing on the wound. The LN called the physician and asked to send the resident to the hospital for evaluation due to the resident being on Lovenox (blood thinner). Emergency Medical Services arrived, and the resident was sent to the hospital at 04:30 PM. The Nurse's Note dated 01/25/26 at 09:30 PM documented R25 returned from the hospital with three sutures in place to the left forehead laceration, which measured two centimeters (cm), and noted a small hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) present. Orders from the hospital directed staff to remove the sutures in seven days. R25 was restless upon return to the facility, and the nurse administered Dilaudid (narcotic pain relief medication) and Xanax (antianxiety medication), which provided effective results. R25's Computer Tomography (CT) scan of the head, brain, and spine was within normal limits.R25's EMR lacked any investigative notes indicating the facility conducted an investigation to determine the root cause of the fall and related interventions to prevent future falls. Upon request, the facility was unable to provide additional investigation information related to the 01/25/26 fall.On 01/27/26 at 11:30 AM, observation revealed R25 sat in a wheelchair, dressed in street clothes. She had a laceration with sutures on her forehead and wore anti-skid socks. Continued observation revealed the resident was able to propel her wheelchair around slowly at the nurse's station.On 01/28/26 at 04:00 PM, Administrative Nurse E stated the medical records documented the resident had a fall with laceration to her forehead on 01/25/26 and verified the facility did not investigate the incident. The facility's Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy, dated 01/01/26, documented the facility would report all allegations of abuse/neglect/exploitation or mistreatment including injuries of unknown sources and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. The License Nurse would:a. Respond to the needs of the resident and protect the resident from further incident.b. Remove the accused employee from resident care areas. c. Notify the Administrator or designee.d. Notify the attending physician, resident's family/legal representative, and Medical Director.e. Monitor and document resident's condition, including response to medical treatment or nursing interventions.f. Document action taken in the medical record.The Administrator or designee would:a. Notify the appropriate agencies immediately; as soon as possible, but o later than 24 hours after discovery of the incident. In the case of serious bodily injuries, no later than 2 hours after discovery or forming the suspicion.b. Obtain statements from direct care staff.c. Suspend the accused employee pending completion of the investigation.d. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service.e. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective action taken, if the allegation was verified. - R44's diagnoses included metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), fracture right femur (thigh bone), pneumonia (a lung infection that causes inflammation and fluid or pus to fill the air sacs of the lungs), and nicotine dependency.R44's admission Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R44 was dependent on staff with activities of daily living (ADL), used a wheelchair for mobility and required staff supervision in the facility. The MDS documented R44 did not use tobacco.R44's Activities of Daily Living Care Area Assessment (CAA) dated 12/22/25 documented the resident required substantial assistance with toileting, bathing, dressing, bed mobility and transfers. The CAA documented that the resident was non ambulatory and used a wheelchair for all mobility. The CAA documented that the resident was alert and oriented.R44's Care Plan dated 12/28/25 directed staff to assist R44 with a stand pivot transfer. The care plan noted R44 used a wheelchair and did not ambulate. The plan lacked interventions related to smoking. R44's Smoking Safety Risk assessment dated [DATE] documented R44 did not currently smoke or use electronic smoking devices.A 01/06/26 Encounter Notes documented R44 smoked half a pack of cigarettes a day.On 01/28/26 at 08:35 AM, observation revealed R44 sat on the side of his bed. Certified Medication Aide R administered R44's morning medications.On 01/27/26 at 04:05 PM, Administrative Staff A verified R44 was admitted to the facility and said a Safe Smoking Assessment was completed but did not identify that the resident smoked. Administrative Staff A verified the staff should have filled out the smoking assessment accurately, to see if R44 was able to smoke safely or and identify if he needed staff assistance Administrative Staff A verified the facility would complete an updated Safe Smoking Assessment for R44.The Smoking Assessment policy, dated 01/02/26, documented that the facility would promote resident centered care by providing a safe smoking area for the residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision unless the facility is a designated nonsmoking facility. The policy documented e-cigarettes and vaporizers would be treated as a traditional cigarette and residents would be assessed by the interdisciplinary team (IDT) and designated as dependent or independent. The policy documented smoking assessments for the residents who requested to smoke would be completed on admission, quarterly and with any change in condition. Assessment for independent or supervised smoking would be determined by the IDT team to assess for level of cognition for safe smoking, level of dexterity to manage smoking and smoking materials, assessment of ability to understand and comply with the policy, and assessment of ability to smoke safely. Smokers would be permitted to smoke only in designated smoking areas on the South patio and outside smoking may be prohibited by the Executive Director if weather conditions are determined to be a risk to resident safety. Facility (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff would secure smoking materials in a locked area when not in use by the residents for both independent and supervised smokers. The facility would document resident and family education in the medical records for acknowledgement of the Resident Smoking policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility had a census of 70 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to establish and implement a system to accurately reconcile the disposition of controlled medications and failed to account for all controlled substances.Findings included:- On 01/29/26 at 10:00 AM, observation of a controlled substance reconciliation revealed one bottle of morphine (narcotic pain medication with high potential for abuse) 20 milligrams (mg) per milliliter (ml) concentrate was unaccounted for.Review of the Pharmacy Spreadsheet revealed the morphine was listed with a prescription number, medication name and date of delivery. The missing medication belonged to Resident (R) 16.On 01/27/26 at 02:55 PM, Licensed Nurse (LN) K stated that at the end of her shift, she counted the narcotics with the oncoming nurse and compared them with the controlled drug administrative record. LN K stated that if the count was off, staff would recount, and if it was still inaccurate, the nurses reported the discrepancy to the director of nursing (DON) or assistant director of nursing (ADON).On 01/26/26 at 03:05 PM, LN G stated that before he left at the end of his shift, counted nad compared the narcotics to the controlled drug administration record with the ongoing nurse. If the count was off, he checked the math on the controlled drug administration record sheet, against the Medication Administration Record (MAR) to make sure the administration matched the count. LN G stated that if the count was still off, he would report to ADON or DON.On 01/28/26 at 12:45 PM, Administrative Nurse E stated that the staffing coordinators were responsible for monitoring the narcotics, but both no longer work at the facility. Administrative Nurse E stated that the night shift managers were also responsible for monitoring the narcotics. Administrative Nurse E verified that the facility did not currently have a system for monitoring narcotics and to identify potential diversion.On 01/29/26 at 11:00 AM, Administrative Staff A and Administrative Nurse D verified R16's bottle of morphine was missing.The facility's Medication Administration Policy, revised 01/01/25, documented narcotics would be signed out in the narcotics log as well as documented in the electronic medical record when given. The policy directed staff not to share or borrow medications from other residents.