STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175226	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Iola	600 E Garfield Street Iola, KS 66749

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 43 residents; the sample included 13 residents. Based on interviews, observations, and record review, the facility failed to protect the dignity of three residents, Resident (R) 2, when R2 was transported from his room to the shower room via a shower chair only covered with a white sheet with his buttocks exposed. Additionally, staff entered the rooms of R2, R7, and R8 without knocking first and did not identify themselves or await acknowledgment from the resident. These deficient practices placed the residents at risk for negative psychosocial effects related to impaired dignity.Findings included:- During an observation on 07/21/25 at 09:58 AM, Certified Nurse Aide (CNA) O knocked on R8's door once and then entered the room without acknowledgement from R8 while he was being interviewed. R8 stated that staff frequently entered his room without knocking or waiting for permission.During an observation on 07/21/25 at 09:25 AM, R7's door was closed, and CNA O opened the door and entered R7's room without knocking or introducing herself.During an observation on 07/21/25 at 09:26 AM, Licensed Nurse (LN) G assisted R2 out of bed, to the toilet, and then assisted him to his chair. While R2 was receiving care, LN F opened R2's door without knocking and looked into the room, looking for another staff member. A few minutes later, CNA O pushed R2's door open without knocking and walked into the room with R2's food tray. During an observation on 07/23/24 at 11:15 AM, staff wheeled R2 from his room to the shower room in a shower chair past the dining room, where other residents were gathering. R2 had a sheet over his lap; his bare legs and bare buttocks were exposed.During an interview on 07/21/25 at 11:40 AM, R7 reported that sometimes staff would just enter her room, or sometimes they would knock first and then enter.During an interview on 07/22/25 at 10:36 AM, CNA L stated that before entering a resident's room, staff were supposed to knock and introduce themselves, then await acknowledgement from the resident before entering. During an interview on 07/22/25 at 10:41 AM, LN H stated that before entering a resident's room, staff should have introduced themselves and awaited resident acknowledgement.During an interview on 07/22/25 at 11:16 AM, Administrative Nurse C stated that staff should have knocked, introduced themselves, and awaited acknowledgement from the resident before entering their room.During an interview on 07/22/25 at 01:53 PM, CNA O stated that she was aware that she needed to be respectful and knock before entering a resident's room.During an interview on 07/23/25 11:21 AM, Administrative Staff A reported that residents should not be transported through the halls with their buttocks or any private areas exposed. During an interview on 07/23/25 at 11:44 AM, CNA N reported that normally, residents were moved from their room to the shower room in their wheelchairs. CNA N also stated that it was not dignified or appropriate to push residents down the hall with exposed privates or only a sheet covering their laps.During an interview on 07/23/25 at 11:50 AM, CNA P reported that it was not safe to push residents in a wheelchair or shower chair down the hall without foot pedals. CNA P also reported that you were not supposed to push residents in the hall on the shower chair, especially if they had exposed areas.The facility's Your Rights and Protections as a Nursing Home Resident policy documented that the residents would have the right to be treated with dignity and respect. The policy further documented that residents would have the right to get proper privacy, property, and living arrangements.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported a census of 43 residents. The sample included 13 residents, with five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure informed consent including purpose, risks versus benefits, and expected therapeutic benefits for the use of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), anxiolytic (medication used to treat symptoms of anxiety) and other psychotropic medications (drugs that affect the brain and nervous system to treat mental illnesses)) for Resident (R)14, R6, R42, R17 and R2. This placed the residents at risk for adverse side effects of the medications and uninformed decisions. Findings included:- R14's Electronic Medical Record (EMR) included the following diagnoses: depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R14's EMR documented the following physician's orders:Sertraline (an antidepressant medication used to treat mood disorders), 50 milligrams (mg), by mouth daily for a diagnosis of depression, ordered 03/24/25.Trazodone (an antidepressant medication), 50 mg, daily at bedtime for a diagnosis of insomnia (difficulty sleeping) ordered 03/24/25.Buspirone (an anxiolytic medication used to treat symptoms of anxiety), 15 mg, three times daily for a diagnosis of anxiety, ordered 03/24/25.Seroquel (an antipsychotic medication used to treat major mental conditions that cause a break from reality), 12.5 mg, three times daily for a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), ordered 04/08/25.R14's EMR lacked documentation of informed consent for R14's psychotropic and antipsychotic medications.On 07/22/25 at 03:35 PM, Administrative Staff A stated the facility had not completed informed consents for R14's antipsychotic and psychotropic medications.The facility policy for Behavior Management & Psychotropic Medications, revised 04/2025, included: An informed consent shall be completed for the use of psychotropic medications prior to the initial administration of the medication and with a dose increase.- R6's Electronic Medical Record (EMR) included the following diagnoses: bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), insomnia (inability to sleep), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R6's EMR documented the following physician's orders:Seroquel (an antipsychotic medication used to treat major mental conditions that cause a break from reality), 12.5 milligrams (mg), every day at bedtime, for a diagnosis of bipolar disease, ordered 04/18/25.Trazodone (an antidepressant medication), 50 mg, daily at bedtime for a diagnosis of insomnia, ordered 04/18/25.Clonazepam (an anxiolytic medication used to treat symptoms of anxiety), 0.5 mg, twice daily for a diagnosis of anxiety, ordered 04/18/25.R6's EMR lacked documentation of informed consent for R6's psychotropic and antipsychotic medications.On 07/22/25 at 03:35 PM, Administrative Staff A stated the facility had not completed informed consents for R6's antipsychotic and psychotropic medications.The facility policy for Behavior Management & Psychotropic Medications, revised 04/2025, included: An informed consent shall be completed for the use of psychotropic medications prior to the initial administration of the medication and with a dose increase.- R42's Electronic Medical Record (EMR) included a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R42's EMR documented the following physician's order:Buspirone (an anxiolytic medication used to treat symptoms of anxiety), 1 milligram (mg), by mouth (three times daily for a diagnosis of anxiety, ordered 03/26/25.R42's EMR lacked documentation of informed consent for R42's psychotropic medications.On 07/22/25 at 03:35 PM, Administrative Staff A stated the facility had not completed informed consents for R42's psychotropic medications.The facility policy for Behavior Management & Psychotropic Medications, revised 04/2025, included: An informed consent shall be completed for the use of psychotropic medications prior to the initial administration of the medication and with a dose increase.- R17's Electronic Medical Record (EMR) included the following diagnoses: anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).R17's EMR documented the following physician's orders:Hydroxyzine (an anxiolytic medication used to treat symptoms of anxiety), 25 milligrams (mg), every 21 hours as needed (PRN), for a diagnosis of anxiety, ordered 06/24/25.Duloxetine (an antidepressant medication), 50 mg, daily for a diagnosis of depression, ordered 05/14/25.Buspirone (an anxiolytic medication), 7.5 mg, by mouth three times daily for a diagnosis of anxiety, ordered 04/02/25.R17's

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility reported a census of 43 residents. The sample included 13 residents. Based on interviews, observation, and record review, the facility failed to ensure a safe, clean home-like environment in all areas of the facility, including the dining area. This deficient practice placed the residents at risk for tripping hazards and decreased comfort.Findings included:- During an observation on 07/21/25 at 09:26 AM, Resident (R) 2's fall mat and room floor had sticky food particles and debris on them. Licensed Nurse (LN) G acknowledged that the mat was filthy and the floor was very sticky and cleaned the mat at that time. During an observation on 07/22/25 at 10:05 AM, the floor area in the dining room had 44 tiles missing; no hazard sign or barrier was blocking the trip hazard.During an observation on 07/22/25 at 10:58 AM, the door on a resident room on the 400-hall displayed bubbling on the surface where the Veneer was separating. The door frames of the doors on the 400-hall had bubbled, chipped, and missing paint.During an observation on 07/22/25 at 11:02 AM, the door frames on the 300-hall had bubbled, chipped, and missing paint. The door on a resident room on the 300-hall displayed bubbling on the surface where the Veneer was separating. Observation on 07/22/25 at 11:02 AM, R2's fall mat had pieces of food on it with sticky areas.During an observation on 07/23/25 at 07:53 AM, the missing tile area in the dining room had no warning or hazard sign in place.During an observation on 07/23/24 at 11:15 AM, the door frames on the 100-hall had bubbled, chipped, and missing paint.On 07/22/25 at 10:05 AM, Dietary CC reported that the tiles in the dining room were removed three weeks ago due to a bathroom pipe leak.On 07/22/25 at 11:02 AM, Certified Nurse Aide (CNA) O reported that she was unsure how long the door frames had been chipped. CNA O also reported that maintenance would periodically repaint them.On 07/22/25 at 11:07 AM, Maintenance X reported that the dining room tiles were removed three weeks ago due to a sewer line blow-out in the service hallway bathroom. Maintenance X reported that he had ordered matching tiles and planned to replace and repair them within the next week. Maintenance X also stated he had been constantly repairing the door frames, at least monthly, and he had been aware of laminate on doors bubbling and had periodically re-glued it back. On 07/22/25 at 03:23 PM, Administrative staff A stated that the floors should have been cleaned at least daily and maintenance should have been notified immediately to repair or replace any tiles. Administrative Staff A said broken or missing tiles were a tripping hazard and should be marked as such to prevent injury.On 07/23/25 at 08:46 AM, Administrative Staff A reported that the door jams should have been maintained and re-painted at least monthly to keep them in proper condition. Administrative Staff A stated that she was unaware of the doors with bubbling laminate.The facility's Your Rights and Protections as a Nursing Home Resident policy documented that the residents would have the right to be treated with dignity and respect. The policy further documented that residents would have the right to get proper privacy, property, and living arrangements.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set for Resident (R) 5 and R14. This placed the resident at risk for impaired care due to unidentified care needs. Findings included:- R5's Electronic Medical Record (EMR) documented a diagnosis of Parkinson’s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and dementia (a progressive mental disorder characterized by failing memory and confusion). R5’s 04/23/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of seven, which indicated severe cognitive impairment. R5 had a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) and was dependent on staff for assistance. The MDS documented R5 had one non-injury fall. R5’s 04/23/25 “Falls Care Area Assessment (CAA) documented R5 had a BIMS score of seven. He had disorganized thinking and was impulsive. R5 required total assistance with care and was transferred using a full-body lift. R5 took antidepressant and anticonvulsant medications and was unaware of safety issues. He had multiple falls before admission and has had one fall since return. R5’s “Fall Note” on 04/20/25 at 09:18 AM documented a noninjury fall. R5’s “Fall Note” on 04/22/25 at 02:25 PM documented a fall with skinned knees. Observation on 07/21/25 at 01:22 PM, R5 lay in bed. The bed was in the lowest position, and there was a fall mat beside the bed. R5’s feet were hanging over the end of the bed. On 07/23/25 at 01:50 PM, Administrative Nurse D stated the 04/23/25 Significant Change MDS for R5 was incorrect and should have documented two falls, one with a minor injury and one with no injuries. Administrative Nurse D said the facility uses the Resident Assessment Instrument (RAI- a comprehensive, standardized tool used in long-term care facilities to assess residents, guide care planning, and monitor quality of care) manual to direct MDS procedures. On 07/23/25 at 12:11 PM, Administrative Staff A stated she expected the MDS to be accurate and completed on time. The RAI Manual documents that it is a requirement that the RAI process accurately reflects the resident’s status. Falls are a leading cause of injury, morbidity, and mortality in older adults. A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls. Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R14's Electronic Medical Record included dementia (a progressive mental disorder characterized by failing memory and confusion). R14's admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. She did not receive anticoagulant medication (medications that decrease the body's ability to clot). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 03/30/25, documented that the resident was able to make her needs known at times. R14's Quarterly MDS, dated [DATE], documented the resident had a BIMS score of eight, indicating severe cognitive impairment. She received an anticoagulant medication during the assessment period. R14's Care Plan instructed staff the resident experienced sundowning (a condition where a person tends to become confused or disoriented toward the end of the day) at times. R14's EMR included the following physician's order:Aspirin (ASA-an antiplatelet medication used to prevent platelets from sticking together and decrease the body's ability to form blood clots), 81 milligrams (mg), daily for health maintenance, ordered 03/24/25. R14's Medication Administration Record (MAR) for July 2025 documented that the resident received the medication daily, as ordered. On 07/23/25 at 09:11 AM, Administrative Nurse D stated R14's Quarterly MDS dated [DATE] was inaccurate. Administrative Nurse D said the resident did not receive an anticoagulant medication during the assessment period but had received an antiplatelet medication. On 07/22/25 at 03:35 PM, Administrative Staff A stated it was the expectation for staff to complete all MDS accurately. The facility utilized the Resident Assessment Instrument (RAI) Manual for accurate completion of the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 residents; the sample included 13 residents. Based on observation, interview, and record review, the facility failed to complete a comprehensive care plan for Resident (R)6 regarding non-pharmacologic pain interventions and for R42 regarding oxygen use. This placed the residents at risk for impaired care due to uncommunicated care needs.Findings included:- R6's Electronic Medical Record (EMR) revealed a diagnosis of trigeminal neuralgia.R6's Significant Change Minimum Data Set (MDS), dated [DATE], documented that the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. She received scheduled and as-needed (PRN) pain medications and reported she had occasional pain, which rarely affected her day-to-day activities and sleep. The MDS noted R6's worst pain in the past five days was rated at a five on a one to 10 pain scale (one being minimal pain and 10 the worst pain imaginable).The Pain Care Area Assessment (CAA), dated 05/21/25, did not trigger.R6's Care Plan, revised 05/14/25, lacked staff instruction for non-pharmacological interventions for pain.R6's EMR revealed the following physician's orders:Carbamazepine (a medication which works by decreasing nerve impulses that cause nerve pain, such as trigeminal neuralgia), 200 milligrams (mg), by mouth twice daily for a diagnosis of trigeminal neuralgia, ordered 07/09/25.Lidocaine viscous HCl mouth/throat solution 2% (a local anesthetic used to numb painful areas of the mouth and throat), 5 milliliters (ml), swish and spit before meals and at bedtime for a diagnosis of trigeminal neuralgia, ordered 04/18/25.R6's EMR documented the resident's pain level was zero on a scale of one to 10 for both shifts on 07/20/25. Staff documented the resident's pain level was a nine on a one to 10 pain scale on the morning of 07/21/25.On 07/21/25 at 09:37 AM, R6 sat in her recliner in her room watching TV. The resident had facial grimacing as she visited with staff.On 07/22/25 at 09:11 AM, Administrative Nurse D stated that non-pharmacological pain interventions should be included on the care plans of residents who have pain.The facility policy for Pain Management, revised 10/22, included: The facility shall implement individualized interventions for residents with pain and document the interventions in the care plan. - R42's Electronic Medical Record (EMR) documented a diagnosis of respiratory failure (a condition where the lungs cannot effectively take in enough oxygen for the blood).R42's admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. She received oxygen during the assessment period.The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/01/25 did not trigger.R42's Quarterly MDS, dated [DATE], documented that the resident had a BIMS score of 13. She received oxygen during the assessment period.R42's Care Plan, revised 06/12/25, lacked staff instruction regarding oxygen use. The resident had no plans to discharge from the facility.R42's EMR documented the following physician's order:Oxygen per nasal cannula (NC), 3-4 liters (L), for a diagnosis of respiratory failure, ordered 03/26/25.On 07/21/25 at 09:47 AM, R42 sat in her room with the oxygen on per NC.On 07/22/25 at 10:19 AM, R42 sat in her room with the oxygen on per NC.On 07/23/25 at 09:11 AM, Administrative Nurse D stated oxygen should be included on the care plan.The facility policy for Electronic Care Plan, revised 12/2020, included: The facility shall develop a plan of care to attain and maintain the highest practical level of physical, psychological, emotional, and social well-being for each resident in the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. The facility identified a census of 43 residents. The sample included 13 residents, with one resident reviewed for urinary tract infections. Based on observation, interview, and record review, the facility failed to provide Resident (R) 5, who had an indwelling catheter (tube inserted into the bladder to drain urine into a collection bag), with appropriate treatment and services to care for a catheter and to prevent urinary tract infections (UTI-an infection in any part of the urinary system). This deficient practice placed the resident at risk for UTI and other catheter-related complications.Findings included:- R5's Electronic Medical Record (EMR) documented a diagnosis of UTI, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and dementia (a progressive mental disorder characterized by failing memory and confusion).R5's 04/23/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of seven, which indicated severe cognitive impairment. R5 had a Foley catheter and was dependent on staff for assistance.R5's 04/23/25 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented R5 required total assistance with care and was transferred using a full body lift. R5 wore briefs and had a Foley catheter. Staff completed incontinence care and catheter care. The CAA noted staff would keep the urine drainage bag below the level of the bladder for dependent drainage. R5's Care Plan on 07/21/25 revealed R5 had an indwelling catheter with an intervention dated 03/31/25 that instructed staff to position the catheter bag and tubing below the level of the bladder. Observation on 07/23/25 at 01:08 PM, Certified Nurse Aide (CNA) P and Certified Medication Aide (CMA) V assisted R5 from the wheelchair to his bed using a Hoyer lift (full body mechanical lift). CNA P and CMA V donned a gown and gloves and hooked up the sling to the Hoyer lift. CNA P attached the Foley bag to the sling at R5's shoulder level, above the level of R5's bladder, and transferred R5 to bed. CMA V unhooked the bag and placed it on the bed beside R5, level to R5's bladder, as they continued. The bag was then attached to the bed frame.On 07/23/25 at 01:15 PM, CMA V stated she was aware that the catheter bag was to be below the level of the bladder at all times. She said she was not thinking about raising the bag for the transfers. On 07/23/25 at 01:35 PM, Licensed Nurse (LN) G stated the catheter drainage bag was to be below the level of the bladder at all times. LN G said the catheter should not be raised higher than the bladder, as that would allow urine to drain back into the bladder.On 07/23/25 at 03:10 PM, Administrative Nurse C said he expected the catheter drainage bag to remain below the level of the bladder. Administrative Nurse C said allowing urine to backflow into the bladder was an infection control issue and could cause urinary tract infections. The facility did not provide a policy for catheter care.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 residents; 13 residents were sampled, including one resident reviewed for pain. Based on observation, interview, and record review, the facility failed to administer pain medications for Resident (R) 6, who had a diagnosis of trigeminal neuralgia (a chronic painful disease that affects the nerve that carries sensation from the face to the brain). This placed the resident at risk of uncontrolled pain. Findings included:- R6's Electronic Medical Record (EMR) revealed a diagnosis of trigeminal neuralgia.R6's Significant Change Minimum Data Set (MDS), dated [DATE], documented that the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. She received scheduled and as-needed (PRN) pain medications and reported she had occasional pain, which rarely affected her day-to-day activities and sleep. The MDS noted R6's worst pain in the past five days was rated at a five on a one to 10 pain scale (one being minimal pain and 10 the worst pain imaginable). The Pain Care Area Assessment (CAA), dated 05/21/25, did not trigger.R6's Care Plan, revised 05/14/25, instructed staff she received pain medications for her diagnosis of trigeminal neuralgia. The care plan lacked direction to staff regarding non-pharmacological interventions for pain.R6's EMR revealed the following physician's orders:Carbamazepine (a medication which works by decreasing nerve impulses that cause nerve pain, such as trigeminal neuralgia), 200 milligrams (mg), by mouth, twice daily for a diagnosis of trigeminal neuralgia, ordered 07/09/25.Lidocaine viscous HCl mouth/throat solution 2% (a local anesthetic used to numb painful areas of the mouth and throat), 5 milliliters (ml), swish and spit before meals and at bedtime for a diagnosis of trigeminal neuralgia, ordered 04/18/25.R6's July 2025 Medication Administration Record (MAR) documented R6 did not receive the bedtime dose of carbamazepine on 07/19/25, both scheduled doses on 7/21/25, and the morning dose on 07/21/25.R6's July 2025 MAR documented R6 did not receive the lidocaine viscous solution for the last two scheduled doses on 07/20/25 and the first two scheduled doses on 07/21/25.R6's Progress Notes in the EMR revealed documentation that staff notified the pharmacy of the need to refill the carbamazepine and lidocaine viscous solution on 07/20/25 and twice on 07/21/25.R6's EMR documented the resident's pain level was zero on a scale of one to 10 for both shifts on 07/20/25. Staff documented the resident's pain level was a nine on a one to 10 pain scale on the morning of 07/21/25.On 07/21/25 at 09:37 AM, R6 sat in her recliner in her room watching TV. The resident had facial grimacing as she visited with staff.On 07/21/25 at 09:37 AM, R6 stated she had not received her pain medication for her trigeminal neuralgia over the weekend and said she was experiencing an increase in pain.On 07/22/25 at 10:35 AM, Certified Medication Aide (CMA) T stated the two medications had not been reordered as they should have been, and the resident did not have them over the weekend. CMA T stated the resident had an increase in facial and mouth pain over the weekend due to not receiving her medications.On 07/22/25 at 02:21 PM, Certified Nurse Aide (CNA) K stated the resident had not complained to her of an increase in pain over the weekend. CNA K stated the resident was able to eat her evening meals without difficulty.On 07/22/25 at 03:35 PM, Administrative Staff A stated the facility expected staff to ensure all residents had sufficient pain medication to get through the weekend.The facility policy for Pain Management, revised 10/22, included: The facility shall develop an individualized treatment plan including pharmacologic and non-pharmacologic interventions for each resident with pain.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility reported a census of 43 residents. Based on interview and record review, the facility failed to complete annual performance evaluations for five Certified Nurse Aides (CNAs) who were employed at the facility for more than 12 months. This placed the residents at risk for decreased quality of care.Findings included:- Review of personnel records on 07/22/25 at 07:25 AM revealed that Certified Medication Aide (CMA) T, CMA U, CNA M, CNA N, and CNA L did not have performance evaluations completed for the last 12 months of full-time employment.During an interview on 07/22/25 at 07:25 AM, Administrative Staff A stated that no performance evaluations were completed for the five CNAs selected for review. Administrative Staff A further stated that she was aware that evaluations should have been completed, but they were not. The facility's Employee Handbook, dated 05/24/20, documented that full and part-time employees should receive formal, written evaluations. Supervisors, administrators/managers/directors are requested to conduct annual performance evaluations. It further documented that every effort would be made to conduct a performance evaluation within two weeks of the employee's anniversary date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility reported a census of 43 residents with two kitchens. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and preparation to prevent the spread of food-borne illness to the residents of the facility. This placed the residents at risk for food-borne illness. Findings included:- Initial tour of the kitchen on 07/021/25 at 08:40 AM with Dietary Manager BB revealed the following areas of concern:The top of the automated dishwasher had dried food debris on it.The ice maker had food particles on the top and sides of it, and food was stored on top of it in storage bags.The kitchen area had multiple fans placed throughout the kitchen., The fans were dirty and dusty and blowing into the food preparation area and the dish cleaning area.There were numerous food items and trash on the floor. The trash cans in the food preparation area were visibly dirty on the outside.The counter where the coffee pot sat had spilled coffee on it.The floors were sticky and slick.Observed on 07/21/25 at 03:50 PM, seven plastic cutting boards were marked and grooved throughout the cutting surface, three large baking sheets had baked-on grease areas in each corner of the cooking surface, and cut marks throughout the cooking surface.Observed on 07/22/25 at 10:05 AM, the counter with the coffee pots had spilled coffee, and the kitchen floor continued to be sticky. There was a broken tile around the clean-out drain by the stove. Observed on 07/22/25 at 10:10 AM, the automated dishwasher continued to have debris on it, and a dirty upright fan was blowing across a drying rack holding clean dishes.Observed on 07/22/25 at 10:20 AM, Dietary Aide CC filled a resident's cup with ice and did not perform hand hygiene or wear gloves before or after handling the cup, and then continued cooking food on the stove. There were food items and other trash on the kitchen floor.On 07/21/25 at 03:55 PM, Dietary Manager BB reported that the cutting boards were not sanitary any longer because they were cut up and the grooves can collect debris and bacteria, and they needed to be replaced. Dietary Manager BB said the stained baking sheets also needed to be replaced. Dietary Manager BB also stated that the fans should have been cleaned, and the automated dish washer should have been cleaned.On 07/22/25 at 10:05 AM, Dietary Aide CC reported that the kitchen was supposed to be cleaned throughout the day as staff worked. On 07/22/25 at 10:10 AM, Dietary Aide DD reported that there had not been a regular cleaning schedule for the automated dishwasher, but it should not have been dirty.On 07/22/25 at 11:07 AM, Maintenance X reported he was aware of the broken kitchen tile; it just had not been replaced yet.On 07/22/25 at 03:23 PM, Administrative Staff A stated that spills should have been cleaned immediately, and the ice maker should not have been dirty. Administrative Staff A also stated that the automated dish washer and fans should be cleaned regularly, and all equipment should be in clean and proper working order. Administrative Staff A further stated that the floors should have been cleaned at least daily, and maintenance should have been notified immediately to repair or replace any tiles. During an interview on 07/23/25 at 08:46 AM, Administrative Staff A reported that the kitchen floors should have been mopped and cleaned twice daily, and if anything had fallen on the floor, it should have been picked up immediately. Administrative Staff A also stated that staff should have regularly performed hand hygiene and should have performed hand hygiene at some point between filling a resident's cup with ice and returning to cooking.During an interview on 07/23/25 at 10:50 AM, Dietary Manager BB reported that the floor should have been mopped and cleaned at least twice daily, and any trash or food on the floor should have been picked up immediately. Dietary Manager BB further stated that hand hygiene should have been performed before and after gloving and before or after filling the ice cup and returning to cooking.The facility Infection Management Process, dated 11/2023, documented that dietary services would use Serve Safe and the Health Technologies Guidelines and Procedure Manual for reference on proper food preparation, management, and dining services. The policy further documented that routine cleaning and disinfection of frequently touched or visibly soiled surfaces in common areas, resident rooms, and at the time of discharge would occur.The facility The Sanitation of Dining and Food Service Areas guideline documented that the dining services staff would uphold sanitation of the dining areas according to a thorough, written schedule. It further documented that the dining services manager would record the necessary cleaning and sanitation tasks for the department, and that all staff would be trained on the frequency of cleaning, and that staff would be held responsible for all cleaning tasks.

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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. (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 reported a census of 43 residents. The sample included 13 residents. Based on observations, interviews, and record review, the facility failed to maintain an effective infection control program related to the Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care). The facility failed to ensure adequate hand hygiene and personal protective equipment (PPE) when caring for residents. Additionally, staff failed to store respiratory equipment in a sanitary manner. This placed the residents at risk for infections.Findings included:- Observation on 07/21/25 at 11:49 AM, Resident (R)'s fall mat next to his bed had cracks and frayed areas exposing the inner foam.Observation on 07/21/25 at 11:52 AM, R7 had a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) with the collection bag resting on the floor next to his bed. There was no PPE for EBP located in or around the room, and no signage alerting staff to the EBP precautions.Observation on 07/21/25 at 01:22 PM, R5's bed was in the lowest position, and his catheter bag was on the floor. The dignity bag was wadded up beside it, partially under it. There was no PPE in or around the room, and no signs instructing staff on EBP.Observation on 07/21/25 at 1:40 PM, R39 had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder). There was no EBP PPE and no signage present.Observation on 07/22/25 at 8:05 AM, Certified Nurse Aide (CNA) O applied a gown and gloves and entered the room to care for R4. CNA O got out the supplies and uncovered R4. She looked for the trash can and retrieved it from the other side of the bed. CNA O removed the fasteners from the side of R4's brief closest to her, then picked up the trash can again and went to the other side of the bed. Wearing the same gloves, CNA O removed the fastener from that side of the brief and cleaned R4's buttocks. Wearing the same soiled gloves, CNA O placed a clean brief under the resident's dirty brief. CNA O then wiped the front peri-area and removed the soiled brief. CNA O adjusted the clean brief, wiped the peri area, and then applied new gloves without performing hand hygiene. CNA O then fastened the brief. CNA O continued dressing R4, then removed the gown and gloves and tied up the trash. She then washed her hands.Observation on 07/22/25 at 11:00 AM, R29's floor mattress was worn at the corners.Observation on 07/22/25 at 1:45 PM, R7's Foley bag rested on the floor. CNA L emptied the bag after washing her hands and donning gloves. CNA L did not apply a gown. CNA L hung the bag so that it was no longer touching the floor.Observation on 07/23/25 at 01:08 PM, CNA P and Certified Medication Aide (CMA) V assisted R5. R5 requested a tissue, and CMA V handed him a tissue. R5 blew his nose and handed the tissue to CNA P. CNA P grabbed the tissue with her ungloved hand and threw it away. CNA P continued assisting R5. She applied a gown without performing hand hygiene and hooked up the sling to the Hoyer lift (full-body mechanical lift). CNA P attached the Foley bag to the sling at shoulder level and transferred R5 to bed. CMA V placed the bag on the bed beside R5 as they continued. CNA N entered the room and applied a gown and gloves. CNA N rolled R5 and removed the sling. CNA N then lowered the bed, removed her gown and gloves, and placed the fall mat on the floor beside R5's bed. CNA N removed her gown and gloves. CMA P then washed her hands and applied a glove to her left hand only to empty the catheter bag. CMA P held the bag with her ungloved hand, opened the spout, and drained the urine. Observation on 07/23/25 at 01:08 PM, CNA P and CMA V assisted R5 to bed. His oxygen concentrator was beside his bed. The oxygen tubing lay on top of the oxygen concentrator, unbagged.On 07/21/25 at 09:26 AM, Licensed Nurse (LN) G stated that the floor mats and floor should be cleaned and disinfected routinely. On 07/22/25 at 01:45 PM, CNA L reported that the Foley tubing and bag should not be on the floor; it should be hanging but below the bladder for proper drainage. On 07/22/25 at 11:16 AM, Administrative Nurse C reported he was not aware of any guidelines concerning EBP for urinary catheters and said he would have to review the guidelines. Administrative Nurse C said the standard precautions were in place only if it was required. Administrative Nurse C verified there was no EBP PPE or signage. Administrative Nurse C confirmed that catheter bags should not touch the floor.On 07/22/25 at 01:53 PM, CNA O stated she caught herself grabbing the clean brief with her dirty gloves. She said she was not aware that hand hygiene should be performed when removing gloves.On 07/23/25 at 11:21 AM, Administrative Staff A reported EBP PPE should be in place with signage for Foley catheters, but suprapubic catheters do not fall under that. She said she expected staff to use proper hand washing, PPE, keep the floor mats clean and in good repair, and provide proper care of Foley catheters.On 07/23/25 at 03:10 PM, Administrative Nurse C reported that he expected the staff to follow infection control guidelines, which included proper hand washing and removal of

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. The facility reported a census of 43 residents. Based on interview and record review the facility failed to ensure the designated Infection Preventionist (IP) was trained and certified in infection prevention and control. This failure placed all 43 residents at increased risk for infectious disease. Findings included: - During an interview on 07/23/25 at 12:11 PM, Administrative Staff A revealed the facility did not have a certified IP. Administrative Staff A stated the previous certified IP left 06/01/25, and the current IP is not certified. During an interview on 07/22/25 at 03:10 PM, Administrative Nurse C, the facility-identified IP, confirmed he was not certified in infection control. The facility's Infection Control Surveillance policy dated 11/2023 documented that the infection control preventionist is to monitor compliance with state and federal regulatory standards as they pertain to infection prevention and control.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility reported a census of 43 residents. Based on interviews and record review, the facility failed to ensure the mandatory 12 hours of education were completed for Certified Nurse Aides (CNA) as required. This placed the residents at risk for decreased quality of care.Findings included:- Review of Certified Medication Aide (CMA) U's personnel and training records revealed CMA U had not completed any of the mandatory 12 hours of education in the last 12 months.On 07/23/05 at 08:46 AM, Administrative Staff A reported that she had performed her own investigation and discovered that CMA U had not completed the mandatory 12 hours of education. Administrative Staff A also reported that the facility did not have a policy related to education, and said the facility follows the regulations.On 07/23/25 at 09:00 AM, CMA U verified that she had not completed the mandatory 12 hours of education for the last 12-month period. The facility did not provide a policy.