STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175236	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hutchinson Operator, LLC	2301 N Severance Street Hutchinson, KS 67502

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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 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 42 residents. The facility identified five Certified Nurse Aides (CNA) employed for more than 12 months. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for four of the five CNAs reviewed. Findings included: - Review of CNA personnel files revealed the following: CNA P, hired on 12/31/24, lacked an annual performance evaluation. CNA Q, hired on 09/04/24, lacked an annual performance evaluation. Certified Medication Aide (CMA) S, hired 07/07/22, lacked an annual performance evaluation. CNA T, hired on 11/21/24, lacked an annual performance evaluation. During an interview on 01/29/26 at 01:52 PM, Administrative Nurse D reported she expected 100 percent compliance in having the annual performances evaluations completed annually. The facility policy Inservice Training Program, Nurse Aide, dated 11/2025, documented the facility would complete an annual evaluation on each nurse aide and utilize such information to validate or change required in-service education.

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 42 residents. Based on observation, interview, and record review, the facility failed to ensure the daily staff posting included the actual hours worked by the nursing staff as required. Findings included:- During an observation on 01/29/26 at 11:50 AM, the daily staff posting document lacked documentation of actual hours worked. Review of the daily staff posting documents from 01/26/26 to 01/29/26 revealed a lack of documentation of actual hours worked. During an interview on 01/29/26 at 11:52 AM, Administrative Staff B stated she had never been educated to post the actual hours worked for the posted staff sheet. During an interview on 01/29/26 at 01:36 PM, Administrative Staff C reported she expected the actual hours to be posted on the staff sheet. The facility did not provide a policy of posted nursing staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility identified a census of 42 residents. The sample included 12 residents. Based on observation, interviews, and record reviews, the facility failed to ensure adequate infection control practices related to 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) and Transmission Based Precautions (TBP-infection control procedures to limit the transmission of infectious agents), sanitization of shared equipment and hand hygiene. Findings included:- On 01/27/2026 at 08:54 AM, Resident (R)38 had signage posted on the door at the entrance to his room which directed staff to use gloves, mask, and gowns prior to entering his room due to Droplet Precautions. A three-drawer rubberized container with personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) was set-up outside of R38's door. On 01/27/2026 at 08:57 AM, Certified Nurse Aide (CNA) Y delivered a meal tray to R38's room. She entered the room with a mask on which she had been wearing throughout the facility while passing meal trays. She set the tray on the resident's overbed table and exited the room without removing her mask or washing/sanitizing her hands. On inquiry, CNA Y verified she should have initiated Droplet Precautions before entering R38's room due to his diagnosis of COVID. She said she should apply a mask, gloves, and a gown before entering his room, and remove PPE and sanitize her hands prior to exiting his room. She stated she was trying to get the meal trays out. On 01/27/2026 at 09:11 AM, R21 reported the staff do not always wear PPE like gowns when providing care. She said she had 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). On 01/27/2026 at 09:20 AM LN H reported she is on EBP as she has a catheter. On 01/27/2026 at 09:27 AM, Administrative Nurse E stated R21 was on EBP due to having a catheter. She reported that not every resident had PPE set up but the signage on the door lets the staff know what type of PPE should be used to care for the residents. She confirmed there were nine residents in the facility with EBP due to catheters and/or MDRO. On 01/27/2026 at 9:37 AM, R25 had signage posted on the door at the entrance to his room which directed staff to use gloves, mask, and gowns prior to entering his room due to Droplet Precautions. A three-drawer rubberized container with personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) was set-up outside of R25's door. The resident was not in his room. He was sitting in a recliner in the adjoining room with his family member who was also a resident. The adjoining room entrance door lacked signage to indicate the room was shared with a resident on TBP. Neither wore a mask on or any type of PPE. R25 was coughing. On 01/27/2026 at 09:39 AM, Certified Medication Aide (CMA) AA verified resident R25 had COVID. She stated the facility had COVID going on three to four weeks. On 01/27/2026 at 09:54 AM, CNA N entered R25's family member's room, checked on R25, and offered ice water. She wore a mask. She spoke to R25 but did not wear a gown, gloves, or eye protection. She exited the room without removing her mask or performing hand hygiene. She confirmed R25 had COVID and said she should wear PPE when around R25 in keeping with droplet precautions. CNA N said she was unaware R25 was in the room until she went in. She stated R25 spent a lot of time in that room, and staff did not use PPE. CNA N stated she was going to inform the nurse about R25's cough. On 01/27/2026 at 10:01 AM observation revealed R20 in his room with his oxygen tubing wrapped around the tank. The cannula hung down and touched the back of the wheelchair. His continuous positive airway pressure (CPAP- ventilation device which blows a gentle stream of air into the nose to keep the airway open during sleep) mask laid directly on the nightstand, and a nebulizer treatment machine was present with clear liquid in the chamber. Further observation revealed he had a peripherally inserted central catheter (PICC-a thin, flexible tube which is inserted into a vein in the upper arm and threaded into a large vein above the heart). R20's room lacked signage direct staff on proper PPE to use while giving direct care. On 01/27/2026 at 10:06 AM Licensed Nurse (LN) H was at her treatment cart. She set up (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wound care supplies for R21'S treatment. She reported she was going to place a dressing on R21's arm. She knocked on R21's door, entered, and applied gloves. LN H did not perform hand hygiene prior to donning the gloves and did not apply additional PPE. R21 reported the dressing had been off since yesterday afternoon when she received her shower, and the nurse last night did not have time to apply one. LN H placed all the dressing supplies on the tray table with some of the open 4x4 gauze pieces touching the tray table. She removed the wet 4x4 she had in a cup, sprayed with wound cleanser, and cleansed R21's left arm areas wounds and scabbed areas which extended from elbow to wrist. She then dried the area, and wearing the same gloves, applied hydrogel (water-based gel which donates moisture and aids autolytic debridement) to all the areas with a Q-Tip. Wearing the same soiled gloves, she opened a clean dressing, applied dressing, and wrapped it with Kerlix. LN H put her scissors back in her pocket, picked up all the supplies and walked out of the room wearing the same soiled gloves. She carried the supplies to the treatment cart. On 01/27/2026 at 10:13 AM, CNA L and CNA N transferred R4, who had an indwelling catheter and required the use of EBP. Neither CNA washed their hands prior to applying gloves nor donned a gown as required with EBP. R4 was incontinent because of a small amount of bowel movement. On 01/27/2026 at 10:49 AM, R4 finished on bedside commode. CNA M and CNA N entered and applied gloves. Without performing hand hygiene prior to applying gloves. CNA M took his gloves off, failed to perform hand hygiene, and exited the room. He returned and reapplied gloves without performing hand hygiene, then grabbed a bag and put R4's feces soiled recliner pad in the bag. Wearing the same gloves, he grabbed the drawer handle, retrieved a wipe, and wiped off the floor which also had feces on it. He took off his gloves and applied new pads to recliner, then applied new gloves. CNA M took R4's catheter bag off the side of the commode, then R4 was raised up and the commode was pulled out. CNA M grabbed the package of wipes and washed R4's buttocks, then grabbed another wipe, reached up to her front peri area, and wiped front to back. After providing care, both CNA removed their gloves but did not perform hand hygiene after removing their gloves. They transferred R4 into her recliner, at which time her catheter bag was hung on the lift and higher than her bladder urine, back flowing up the tube towards the bladder. CNA N then pushed the lift out of the room but did not sanitize it. She left it in the hallway. On 01/27/2026 at 11:13 AM, CNA M stated he did not think he had to wash his hands after he removed gloves, and he thought he only needed gloves with a resident who was on EBP, On 01/27/2026 at 11:21 AM, CNA N stated she did not know she was supposed to wear gowns with resident on EBP. She reported she should have kept R4's catheter bag below her bladder. Observation on 01/28/25 at 07:35 AM, revealed R20 sat in his recliner with a half-full urinal on his over bed table. His CPAP mask remained on the nightstand. An observation on 01/28/2026 at 09:36 AM revealed Consultant JJ and LN G entered R20's room after they had a discussion whether R20 was on EBP or Covid TBP, as he had no sign on his door. Consultant JJ reported she believed he was not on any type of precautions anymore. Consultant JJ placed a bag of 4x4s and a wound bottle on R20's tray table which had half-full urinal and an empty breakfast tray on it as well. Consultant JJ applied gloves, picked up the breakfast tray, and gave it to the dietary aide. Wearing the same gloves, she assisted in rolling R20, then pulled down his brief and removed his dressing. There were feces on the dressing. She cleansed the area with 4x4 and wound cleanser which she grabbed with her gloved hands. Consultant JJ took a Q-tip out of her bag of supplies on the tray table and inserted it into the wound. LN G then carried those supplies into R11's room. During an interview on 01/28/26 at 09:55 AM, LN G reported she did take the same open package of 4x4's and wound cleanser bottle into each residents' rooms. She reported she should not have placed the wound supplies on the tray table, and she usually took a cup with wound cleanser and 4x4s in the rooms instead of the same supplies into each room. She said she should not have placed the supplies on the tray table without a barrier. She said she should have washed her hands prior to applying gloves and she should not have picked up the tray with the same gloves she used to remove and cleanse the wound. She reported R21 should have had EBP after she realized he had a PICC line. She also reported she should have washed her hands after removing her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gloves before she touched items. Consultant JJ reported she had no place to put her supplies in a resident's room, and she could not keep a hold of the bag and then reported that maybe they should have a treatment cart on the wound rounds to just take in what is needed for each individual resident. During an interview on 01/28/26 at 10:15 AM, LN H reported she did not realize she wore the same gloves and reported she should have worn all the PPE required when providing care to R21. On 01/28/2026 at 02:34 PM, CNA Y exited a resident's room with a full body lift after giving direct care and proceeded down the hall to enter another resident room without sanitizing the lift between resident use. LN J confirmed the staff should sanitize lift in between residents. He stated it had been a long time since he had seen a lift sanitized. On 01/28/2026 at 05:10PM, Consultant GG confirmed the above findings were inadequate infection control practice. She reported the facility should utilize proper infection control techniques to include proper use of PPE, hand hygiene, and sanitizing reuseable equipment to prevent the spread of infection and cross contamination. The facility policy, titled Cleaning and disinfection of Environmental Surfaces F880, documented environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Blood borne Pathogens standards. Protective gloves, masks, and other appropriate PPE will be used. Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Objects which enter sterile tissue (e.g., urinary catheters) or vascular system (e.g. intravenous catheters) are considered critical items and must be sterile.

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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 identified a census of 42 residents. Based on interview and record review, the facility failed to ensure the designated Infection Preventionist (IP) possessed the required certification. Findings included: - Upon request, the facility was unable to provide proof of certification for the designated IP. On 01/28/2026 at 05:30 PM, Administrative Nurse E stated she was the designated IP. She stated she had not completed the certification course in infection control prior to her appointment to the position about a month ago. Administrative Nurse E stated she was about halfway through the course requirements for certification. The facility did not provide a policy related for certification and qualification of the IP.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 identified a census of 42 residents. The sample included 12 residents with five residents reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to ensure staff provided ADL assistance with personal hygiene for Resident (R) 4, R21, R7 and R40, who did not receive fingernail care and/or showers. Findings included:1.R4's Electronic Medical Record (EMR) recorded a diagnosis of bladder dysfunction and inflammatory reaction due to an indwelling urethral (tubelike part of the body conveys urine from the bladder to the exterior) catheter and bipolar disorder (a major mental illness which causes people to have episodes of severe high and low moods). R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R4 had no rejection of cares during the observation period. The MDS noted R4 was dependent on staff for most ADL, including showering and personal hygiene. R4's Care Plan, dated 11/29/17, informed staff that R4 prefers to bathe in the afternoons twice a week. The Shower List, dated 12/19/25, had R4 scheduled for a shower on Tuesday, Thursday, and Saturday. R4's Shower Sheets, reviewed from 11/05/25 through 01/27/26, revealed R4 had 39 showers scheduled. R4 received eight showers, two bed baths, she refused twice as showers were offered in the morning, and one time she refused as she was ill. During an observation and interview on 01/27/26 at 9:36 AM, R4 in her recliner, she reported she should receive a shower Tuesday, Thursday, and Saturday. She reported she had no shower last week except for a bed bath on Saturday, as it was too cold to have a shower in the shower room. R4 reported she disliked bed baths, as she did not get cleaned well in her bed. During an interview on 01/28/26 at 01:20 PM, R4 reported she did not have a shower again the previous night; staff told her the water was shut off for the shower room because there was a leak which was being fixed. She reported she was quite sad she had not received a shower in over a week. 2. R21's EMR recorded diagnoses of sepsis (a life-threatening systemic reaction which develops due to infections which causes inflammation throughout the entire body) and neuromuscular dysfunction of the bladder (a condition where nerve disease or injury disrupts signals between the brain and the bladder). 3R21's Quarterly MDS, dated 01/09/26, recorded a BIMS score of 15 indicating intact cognition. R21 had no rejection of care during the observation period. R21 was dependent on staff for toileting hygiene, and showers and required maximal/extensive staff assistance with personal hygiene. R21's Care Plan, dated 07/30/24, educated staff R21 had an ADL self-care performance deficit related to weakness. R21's care plan lacked documentation regarding bathing preferences or assistance required. The Shower List, dated 12/19/25, had R21 scheduled for a shower on Monday and Friday. R21's Shower Sheets, reviewed 11/05/25 through 01/27/26, revealed R21 had 27 showers scheduled. R21 received one shower, four bed baths, she refused one time as she was ill. Two of the scheduled days she was in the hospital. During an observation an interview on 01/27/26 at 09:11 AM, R21 laid in her bed and watching television. She reported she had a shower the previous day, but before then, the last shower was 01/12/26. R21 reported the facility was frequently short staffed and said she did not always get a shower at least twice a week. She stated there was only one functional shower room because the other was down. R21 said she preferred her showers in the afternoon because she liked to go to activities like BINGO. She missed BINGO the previous day, as she had her shower before the activity, and there was not a dry lift sling available for use to get her up after her shower and go to BINGO. 3. R7's EMR documented diagnoses of urinary retention (lack of ability to urinate and empty the bladder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R7's Quarterly MDS, dated 12/12/25, recorded a BIMS score of 13 indicating intact cognition. R7 had no rejection of care during the observation period. R7 was dependent on staff for toileting hygiene, showers, and dressing. She had an indwelling catheter. R7's Care Plan, revised date 02/12/25, educated staff R7 had an ADL self-care performance deficit related to weakness/limited (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobility. R7's care plan lacked documentation regarding personal hygiene/nail care assistance required. During an observation on 01/27/26 at 02:30 PM it was revealed R7 had long, dirty fingernails. During an observation on 01/28/26 at 07:33 AM, R7 was in bed watching TV. The room smelled strongly of urine Her fingernails were long, jagged, and had brown debris under the nails. During observation on 01/28/26 at 12:15 PM, R7 was in the dining room eating lunch. Her fingernails remained long, jagged and she had brown debris under her nails. R7 reported she could not cut her nails; she would need help. Observation on 01/29/26 at 09:07 AM revealed R7 was in bed with her eyes closed. There was a strong urine smell present in her room. Her fingernails were unchanged from previous observations. 4. R40's EMR recorded diagnoses which included hypertension (high blood pressure) and depression (a mood disorder which causes a persistent feeling of sadness and loss of interest) and COVID-19. R40's Quarterly MDS, dated 01/09/26, documented a BIMS score of 15. He had no rejection of care during the observation period. He was dependent for showering and required maximal /extensive assistance for personal hygiene. R40's Care Plan, 06/09/22, educated staff R40 had an ADL self-care performance deficit related to an unsteady gait. R40's Care Plan, 09/02/22, directed staff R40 required one staff participation with bathing and R40 preferred evening baths twice a week. The Shower List, dated 12/19/25, had R40 scheduled for a shower on Wednesday, Friday, and Sunday. R40's Shower Sheets, reviewed 11/03/25 through 01/21/26, documented R40 had his nails clean and trimmed four times, last time documented was 01/11/26. The facility was unable to provide shower sheets from 01/22/26 through 1/27/26. R40 had a shower documented on 01/21/26. During an observation and interview on 01/27/26 at 01:20 PM, R40 stood at the bathroom sink washing his hands. R40 reported it was almost two weeks since his last shower. He said he thought it was due to the fact he had COVID but went on to say he still needed to get bathed. During an observation and interview on 01/28/2026 at 8:45 AM, R40 was seated in his recliner observed to have very long jagged fingernails with brown color residue underneath nails, visible from the tops and the backsides of hands. R40 asked if someone was going to cut his nails for him, then reported no one else would help him.During an observation and interview on 01/27/26 at 01:20 PM, R40 stood at the bathroom sink washing his hands. R40 reported it was almost two weeks since his last shower. He said he thought it was due to the fact he had COVID but went on to say he still needed to get bathed. Review of Resident Council Concerns Form, dated 12/19/25 and 01/23/26, concern documented on both was showers not being completed when scheduled. Recommendations/Solutions both forms were dated 01/26/26 and documented educated staff Administrative Nurse D would review shower sheets and will discipline staff who do not complete. During an interview on 01/28/26 at 02:34 PM, Certified Medication Aide (CMA) R produced an updated shower list, dated 12/19/25. CMA R reported the residents only get showers from 06:00 AM-06:00 PM. CMA R reported residents do not get showers offered on the night shift. Additionally, CMA R reported the facility had only one working shower room since last year. CMA R reported if a resident missed a shower they should document why, and sometimes they would not get them done. Additionally, CMA R reported the staff would trim and clean the residents' nails who could not complete it independently. During an interview on 01/29/26 at 09:15 AM, Licensed Nurse (LN) G reported showers had been very difficult to correlate between North and South hallway, as the facility was down to one shower room since August 2025. LN G reported if a resident missed a shower, it would be ideal to have that shower made up the next day. LN G reported it would not always happen. LN G reported the staff were required to trim and clean residents' fingernails during the bath day or as needed. During an interview on 01/29/26 at 01:52 PM, Administrative Nurse D revealed the facility had one shower which both the North and South hallways had to share. She reported the North hallways shower room had been under repair since August 2025. Administrative Nurse D reported she expected the showers to be completed and had been working on a plan to have the issue resolved. Additionally, she expected the staff to trim and clean residents' nails on shower days and as needed. The facility's policy Quality of Life - Activities of Daily Living, dated 04/2025, documented residents who are unable to carry out activities (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of daily living would receive the necessary care and services to maintain good grooming and personal hygiene. The facility's policy Shower/Tub Bath, dated 10/2025, documented the purposes of this procedure are to promote cleanliness, provide comfort to the residents, observe the condition of the skin, and to not trim the residents' fingernails unless otherwise instructed by the supervisor.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility reported a census of 42 residents; the sample included 12 residents with five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to acknowledge the Consultant Pharmacist's monthly medication regimen review (MRR) and failed to ensure the MRR recommendations were filed in the clinical record for Resident (R) 1, R3, R6, R20, and R33. Findings included:1. R1's Electronic Medical Record (EMR) recorded the following Medication Regimen Review (MRR): R1's Pharmacy Consultant Note on 09/25/2025 documented MRR completed, irregularities noted, see report. R1's Pharmacy Consultant Note on 10/24/2025 documented MRR completed, irregularities noted, see report. R1's Pharmacy Consultant Note on 12/11/2025 documented MRR completed, irregularities noted, see report. R1's clinical record lacked the actual recommendations made and lacked evidence that the facility and physician acknowledged and responded. 2. R3's EMR recorded the following MRR: R3's Pharmacy Consultant Note on 10/25/25 documented MRR completed, irregularities noted, see report. R3's Pharmacy Consultant Note on 12/11/25 documented MRR completed, irregularities noted, see report. R3's clinical record lacked the actual recommendations made and lacked evidence that the facility and physician acknowledged and responded. 3. R6's EMR recorded the following MRR: R6's Pharmacy Consultant Note on 10/16/25 documented MRR completed, irregularities noted, see report. R6's Pharmacy Consultant Note on 11/21/25 documented MRR completed, irregularities noted, see report. R6's clinical record lacked the actual recommendations made and lacked evidence that the facility and physician acknowledged and responded. 4. R20's EMR recorded the following MRR: R20's Pharmacy Consultant Note on 09/26/25 documented MRR completed, irregularities noted, see report. R20's Pharmacy Consultant Note on 10/24/25 documented MRR completed, irregularities noted, see report. R20's Pharmacy Consultant Note on 12/11/25 documented MRR completed, irregularities noted, see report. R20's clinical record lacked the actual recommendations made and lacked evidence that the facility and physician acknowledged and responded. 5. R33's EMR recorded the following MRR: R33's Pharmacy Consultant Note on 10/24/25 documented MRR completed, irregularities noted, see report. R33's clinical record lacked the actual recommendations made and lacked evidence that the facility and physician acknowledged and responded. During an interview on 01/29/26 at 11:32 AM, Administrative Nurse D reported she would not have any of the MRRs before 12/02/25 and could not locate MRRs which were requested. Administrative Nurse D reported she expected the MRRs to be answered within seven days after they were received from the pharmacist. The facility's policy Medication Regimen Reviews, dated 02/2025, documented the Consultant Pharmacist shall review the medication regimen per state and federal guidelines. Reporting of irregularities to the attending physician, the facility medical director, and the Director of Nursing. Provision of irregularity reports on a separate, written report (to those identified in a), which includes the resident's name, the relevant drug, and the irregularity which has been identified.

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	175236	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hutchinson Operator, LLC	2301 N Severance Street Hutchinson, KS 67502

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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. The facility identified a census of 42 residents, two medication rooms and four medications carts. Based on observation, record review, and interview, the facility failed to store insulin (a hormone that lowers the level of glucose in the blood) appropriately to include an opened date on insulin pens in use. Findings included:- Observation on 01/28/26 at 08:29 AM revealed the following insulin pens were open, and undated. 1. Resident (R) 2's Lantus (long-acting insulin) had no label or open date. Her insulin lispro (fast-acting insulin) had no legible open date. 2. R15's insulin lispro had no open date. 3. R4's Lantus has no open date. 4. R17's glargine (long-acting insulin) had no cap and no open date. According to medlineplus.gov, open Lantus, glargine, and insulin lispro pens must be stored at room temperature and may be used for up to 28 days after the first use. During an interview on 01/28/26 at 08:29, AM Licensed Nurse (LN) J reported that the insulin pens should b e labeled when opened. During an interview on 01/29/26 at 08:55 AM, Administrative Nurse D stated she expected the staff to label the insulin pens with an open date. The facility did not provide a policy for medication storage.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 42 residents; the sample included 12 residents with five reviewed for unnecessary medications. Based on interview and record review, the facility failed to inform Resident (R) 3 and R20 and/or their representatives regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included:1. R3's Electronic Medical Record (EMR) documented an order for olanzapine (antipsychotic medications used to treat major mental conditions that cause a break from reality) five milligrams (mg) by mouth once daily, dated 06/25/25. R3's EMR lacked evidence R3, or her representative, received education and/or informed consent with regards to the olanzapine dose and frequency increase. 2. R20's EMR documented an order for trazodone (antidepressant) 50 mg by mouth every 24 hours at bedtime as needed for insomnia (inability to sleep), dated 10/10/25. The order lacked a stop date. The EMR noted an order for citalopram hydrobromide (antidepressant medication) 40 mg daily by mouth, dated 10/10/25. R20's EMR lacked evidence R20, or his representative, received education and/or informed consent with regards to the Celexa and trazadone. During an interview on 01/29/26 at 09:15 AM Licensed Nurse (LN) G reported that Social Service Designee (SSD) X would complete the informed consents for the use of psychotropic medications. During an interview on 01/29/26 at 12:00 PM SSD X reported she could not locate the informed consents for R20 and produced signed consents for R20's trazadone and Celexa dates 01/29/26. SSD X reported she would have the resident or responsible party complete the consent when a new psychotropic medication was ordered. During an interview on 01/29/26 at 01:52 PM, Administrative Nurse D reported she expected the informed consents for psychotropic medications to be obtained prior to a medication being administered to a resident. The facility's policy Use of Psychotropic Drugs, dated 04/2025, documented the facility would inform the resident and or/representative of a new or changed orders for a psychotropic medication, including the benefits, risks, and alternatives for the medications, which included a black box warning for psychotropic medication prior to being initiated or increased.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility identified a census of 42. The sample included 12 residents with three reviewed for beneficiary notifications. Based on interviews and record review, the facility failed to use the appropriate Advance Beneficiary Notice of Notice of Non-coverage (ABN) Form CMS-10055 and failed to ensure section G recorded the resident's selection for Resident (R) 4 and R6 and failed to issue the ABN to R35. The facility failed to issue the Notice of Medicare Non-Coverage for R35. Findings included:1. R4's facility provided documentation noted her Medicare Part A last covered day was 11/20/25. The resident remained in the facility. R4's ABN Form CMS-R-131, dated 11/20/25, lacked section G selection. 2. R6's facility provided documentation noted his Medicare Part A last covered day was 07/23/25. The resident remained in the facility. R6's ABN Form CMS-R-131, dated 11/20/25, lacked section G selection. 3. R35's facility provided documentation revealed his Medicare Part A services ended 12/24/25. The resident remained in the facility. Upon request, the facility was unable to provide evidence that Form CMS-10055 or Form CMS-10123 were provided to R35. In an interview with Administrative Nurse F on 01/29/26 at 02:57 PM, he stated the ABN should be provided to the resident or resident's representative, so the notification can be appealed, if chosen to do so, prior to the last day of Part A coverage. The facility's policy F582, F584 Beneficiary Notice, last revised on 08/2024, documented the Skilled Nursing Facility ABN is issued to the resident if resident intends to continue services which may no longer be covered by Medicare.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 identified a census of 42 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to maintain a clean, homelike environment for Resident 33, R7, and R40. Findings included:- An observation on 01/27/2026 at 08:59 AM revealed R33's room had a strong foul odor, and his linen on his bed was dirty and gray in color. An observation on 01/27/2026 at 01:20 PM revealed R40's recliner had vinyl peeling off the chair. He said the recliner was broken and he thought he had reported it. An observation on 01/28/2026 at 07:33 AM revealed R7 laid in bed watching TV. The room had a strong urine odor. An observation on 01/28/2026 at 08:06 AM revealed Certified Medication Aide (CMA) R opened the door to R33's room, and strong foul odor was evident from the room all the way out in the hallway. His sheets remained the same dirty sheets as the previous day. An observation on 01/28/2026 at 10:47 AM revealed R40 had a pile of food crumbs and dirt in front of his chair, and red dried smears on his tray table. The tray table had duct tape on it in two different places. An observation on 01/29/2026 at 9:07 AM R7 was in bed with her eyes closed. There was a strong urine smell present in her room. Her catheter (tube inserted into the bladder to drain urine) bag was not covered and there was no urine visible in the bag. During an interview on 01/28/2026 at 08:06 AM, CMA R stated she had not noticed how soiled R33's sheets were when she was in the room to give R33 his medications. During an interview on 01/28/2026 at 08:08 AM, Certified Nurse Aide (CNA) O reported R33 would allow staff to change his linens on his bed, and it would be completed on shower days or as needed. CNA O reported R33's room always had a foul odor and management staff had spoken to him about the smell. CNA O reported R33 would not allow staff to touch his boxes in his room. During an interview on 01/28/2026 at 08:10 AM, CNA O reported R7's room smelled of urine quite often and R7 had a foley catheter and stated maybe the urine was spilled when the staff drained the catheter bag. During an interview on 01/28/2026 at 08:13 AM, R33 reported he would allow staff to clean his room, and no staff had spoken to him about the odor in his room. R33 stated no staff had asked him to assist him with his boxes. He reported he had a shower on 01/27/26 in the evening and his dirty laundry was in the basket in his room. During an interview on 01/28/26 at 12:09 PM, Housekeeping Staff W reported R33's room smelled foul all the time, and R33 was scheduled for a daily cleaning of his room. Housekeeping Staff W reported sometimes R33 would not leave his room so the staff could not always clean under his bed. Housekeeping Staff W reported R7 had a strong urine smell in her room often and was not sure why. During an interview on 01/28/2026 at 02:21 PM, Housekeeping Staff W reported staff typically cleaned R40s's room twice a day because he was messy and gross. She said staff had to go into R40's room and get stuff off the floor with a paint scraper. She also stated staff had not cleaned R40's room the previous day at all, nor had they done it that day either. During an interview on 01/29/26 at 09:15 AM Licensed Nurse (LN) G reported housekeeping staff cleaned all the residents' rooms daily. During an interview on 01/29/26 at 01:52 PM Administrative Nurse D reported she expected the residents' rooms to be cleaned daily. Administrative Nurse D reported the facility had tried to remove the foul odor from R33's room and had been unsuccessful. She expected the residents' rooms not to have a lingering odor in their rooms. The facility's policy Cleaning and Disinfection of Environmental Surfaces, dated 10/2025, documented routine cleaning and disinfection should be completed of frequently touched or visibly soiled surfaces in common areas, resident rooms, and at time of discharge. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. The facility identified a census of 42 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 6 and R20's as needed (PRN) psychotropic medication (alters mood or thoughts) had a 14 day stop date, or a specified duration with a physician rationale for extended use. The facility failed to ensure R6's PRN antipsychotic (a psychotropic medication used to treat severe mental disorders) had the required 14 day stop date. Findings included:1. R6's Electronic Medical Record (EMR) listed a Physician's Order for haloperidol (an antipsychotic medication) 0.5 milligrams (mg) tablet, give one tablet by mouth every four hours as needed for agitation/aggression, dated 10/18/25. The order lacked a stop date. R6's EMR documented an order lorazepam (antianxiety a class of medications that calm and relax people) 0.5 mg tablet, give one tablet by mouth every two hours as needed for anxiety/seizure, dated 11/04/25. The order lacked a stop date. An observation on 01/28/26 at 09:50 AM revealed R6 walked in the hall using a walker. He had no behaviors and answered questions with ease. 2. R20's EMR documented an order trazodone (antidepressant) 50 mg by mouth every 24 hours at bedtime as needed for insomnia (inability to sleep), dated 10/10/25. The order lacked a stop date. Observations on 01/28/26 at 07:35 AM revealed R20 sat in his recliner. He reported he did not get much sleep last night. During an interview on 01/29/26 at 09:15 AM Licensed Nurse (LN) G reported all as-needed psychotropic medication orders required a 14 day stop date. LN G reported the nurse who documented the order in EMR was responsible to document a stop date. During an interview on 01/29/26 at 01:52 PM Administrative Nurse D reported she expected all as-needed psychotropic medications to have a 14 day stop date to have medication re-assessed. The facility's policy Use of Psychotropic Drugs, dated 04/2025, documented as needed orders for all classes of psychotropics. Antipsychotic medications enter a 14 day stop date. To renew the as-needed order, the physician must evaluate the resident for appropriateness to write an additional 14 days for that medication. All other psychotropic medications enter a 14 day stop date. Repeated doses given with the 14 days should be reviewed for standing dose.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 42 residents. The sample included 12 residents with two reviewed for discharge and three for hospitalization. Based on interviews and record review, the facility failed to provide a written bed hold policy including duration for Resident (R)21, and R20. The facility also failed to notify the Office of the Long-term Care Ombudsman (LTCO) of a transfer for R46.Findings included:1.R21's Electronic Medical Record (EMR) recorded a Quarterly Minimum Data Set (MDS), dated [DATE], which documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R21's Nursing Progress Note, dated 01/02/26 at 06:36 AM, which documented R21 was admitted to the hospital with urosepsis (sepsis related to UTI) and a verbal bed hold was given before departure. R21's EMR lacked evidence a written bed hold notice was provided to R21. During an interview on 01/27/26 at 09:11 AM, R21 reported she did not know anything about a bed hold. 2. R20's Quarterly MDS, dated 12/30/25, documented a BIMS score of 15. R20's Nursing Progress Note, dated 01/17/26 at 08:40 AM, documented the resident was unresponsive. Staff notified the physician who gave orders to send the residents to the emergency room. The note documented the resident was unable to sign a bed hold because he was unresponsive. The note also lacked evidence that a written bed hold was sent with the resident or provided to his party responsible. During an interview on 01/27/26 at 12:26 PM, R20 reported he had no knowledge what the bed hold policy was or if one had been done. 3. R46's admission MDS, dated 12/06/25, recorded a BIMS score of 15. R46's EMR included a note, dated 12/08/25 at 05:47 PM, which documented R46 discharged from the facility at approximately 05:45 PM via a private vehicle in route to his new home accompanied by a family member. The discharge summary and medication orders were provided to the resident and his representative upon discharge. Upon request, the facility was unable to provide evidence the LTCO received notification of the discharges. During an interview on 01/28/26, Social Service Designee (SSD) X revealed she had not updated the LTCO since 08/25/25 for transferred/discharged residents. During an interview on 01/29/26 at 09:15 AM, Licensed Nurse (LN) G reported that a bed hold would be completed at the time of transfer to the hospital, if it was not completed a copy of the bed hold would be sent. LN G reported SSD X would complete a bed hold the next day if not completed. During an interview on 01/29/26 at 09:35 AM, SSD X reported that the nurse would complete a bed hold when a resident was transferred to the hospital. SSD X reported she would be told if a bed hold was not completed and then a bed hold would be obtained. During an interview on 01/29/26 at 01:52 PM, Administrative Nurse D reported she expected the bed holds to be completed in a timely manner. Administrative Nurse D reported she expected the LTCO to be updated monthly on all transfers. The facility's policy Bed Hold, dated 04/2025, documented the staff shall inform resident upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed hold policy. When emergency transfers are necessary, the facility would provide the resident and the resident's representative with information of the bed hold policy per state law as applicable. A copy of the resident's bed hold, or release record would be filed in the resident's medical record. The facility's policy Transfer and/or Discharge, Including Against Medical Advice, Discharge notification, dated 10/2025, documented would send a copy to the notice of the State Long Term Care Ombudsman, note in record.

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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. The facility identified a census of 42 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for Resident (R) 20's psychotropic (alters mood or thought) medications, and R7's activities of daily living (ADLs) for a dependent resident. Findings included:1. R20's Electronic Medical Record (EMR) revealed diagnoses of major depressive disorder (major mood disorder which causes persistent feelings of sadness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R20's 09/29/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R20's MDS documented no behaviors and minimal depression. R20's MDS recorded he received an antianxiety, (a class of medications which calm and relax people), an antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality), and an antidepressant (a class of medications used to treat mood disorders) in look-back period. R20's 10/17/25 Psychotropic Drug Use Care Area Assessment (CAA) documented R20 triggered related to high-risk medications. R20 would continue to take medication as prescribed by provider. Medications would be reviewed by provider for therapeutic effect. R20's Care Plan, revised date 01/05/26, documented R20 used antidepressant, psychotropic, and antianxiety medications. The care plan lacked documentation for any interventions related to his mental health medications. R20's Physician's Orders documented trazadone (antidepressant medication) 50 milligrams (mg), give one tablet every 24 hours as needed, by mouth, for insomnia, date ordered 10/10/25. R20's Physician's Orders documented Celexa (antidepressant medication) 40 mg, give one tablet, by mouth, daily for depression, date ordered 10/11/25. R20's Physician's Orders documented Caplyta (antipsychotic medication) 10.5 mg, give one tablet at bedtime for depression, date ordered 12/05/25. R20's Physician's Orders documented lorazepam (antianxiety medication) 1 mg, give one tablet twice a day for anxiety, date ordered 01/24/26. Observations on 01/28/26 at 07:35 AM revealed R20 sat in his recliner. He reported he did not get much sleep last night. 2. R7 's EMR revealed diagnoses of major depressive disorder (major mood disorder which causes persistent feelings of sadness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R7's 05/17/25 Annual MDS documented a BIMS score of 10, which indicated moderately impaired cognition. R7's MDS documented she had an impairment on both her upper and lower extremities. R7's MDS documented she required total assistance with personal hygiene. R7's 06/13/25 Functional Abilities (Self-Care and Mobility) CAA documented R7 triggered related to a self-care deficit. R7's 11/77/25 Quarterly MDS documented a BIMS score of 13, which indicated intact cognition. R7's MDS documented she had an impairment on both her upper and lower extremities. R7's MDS documented she required total assistance with personal hygiene. R7's Care Plan, revised date 02/12/25, educated staff that R7 had an ADL self-care performance deficit related to weakness/limited mobility. R7's Care Plan lacked documentation regarding personal hygiene/nail care assistance required. During an observation on 01/27/26 at 02:30 PM, it was revealed R7 had long, dirty fingernails. During an observation on 01/28/26 at 07:33 AM, R7 was in bed watching TV. Her fingernails were long, jagged, and had brown debris under the nails. During observation on 01/28/26 at 12:15 PM, R7 was in the dining room eating lunch. Her fingernails remained long, jagged and she had brown debris under her nails. R7 reported she could not cut her nails; she would need help. During an observation on 01/29/26 at 09:07 AM, R7 was in bed with her eyes closed. Her fingernails were unchanged from previous observations. During an interview on 01/29/2026 at 02:56 PM Licensed Nurse (LN) K reported care plans are developed by the Administrative Nurses. During an interview on 01/29/26 at 02:58 PM, Administrative Nurse E reported R20's psychotropic medications should have been documented on the care plan within 30 days. Administrative Nurse E reported a care plan is developed by the interdisciplinary team and expected (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care plan to be an accurate up to date. The facility's policy Comprehensive Care Plans, dated 03/25, documented an individualized comprehensive person-centered care plan, which included measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological needs, was developed for each resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 42 residents. The sample included 12 residents with three residents reviewed for urinary catheters (a tube inserted directly into the bladder to drain urine). Based on observation, interview, and record review, the facility failed to ensure adequate catheter related care for Resident (R) 4, R7 and R21 when staff did not ensure each resident's catheter tubing was secured to prevent pulling or dislodgement. The facility additionally failed to ensure each resident was provided with a dignity bag to cover the urine collection bag and failed to ensure the urine collection bags remained sanitary and off the floor. Findings included:1.R4's Electronic Medical Record (EMR) recorded a diagnosis of bladder dysfunction and inflammatory reaction due to an indwelling urethral (tubelike part of the body conveys urine from the bladder to the exterior) catheter.R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. R4 had no rejection of cares during the observation period. The MDS noted R4 was dependent on staff for most activities of daily living (ADL). She had an indwelling catheter. R4's Care Plan, dated 02/04/25, directed staff to provide foley catheter care. Change the foley catheter as needed. Directed staff to observe catheter tubing for kinks and to keep the foley catheter below the level of the bladder. R4's EMR listed the following orders: Indwelling catheter, 20 French (Fr) 30 cubic centimeters (cc), change catheter and bag as needed for signs and symptoms of infection, obstruction or when the closed system has been compromised as needed, dated 10/11/25. During an observation on 01/27/26 at 10:13 AM, Certified Nurse Aide (CNA) M and CNA N transferred R4 with mechanical lift onto the bedside commode. Her catheter tubing was not secured onto her skin, the catheter tubing hung freely. During an observation on 01/28/26 at 07:40 AM, R4 was in her recliner with her eyes closed. Her urine collection bag hung on the garbage can with no cover. The bag touched the floor.During an interview on 01/27/2026 at 11:21 AM, CNA N stated good luck when asked if the facility had securement devices for catheter tubing available.During an interview on 01/28/26 at 01:20 PM, R4 reported she was being treated for another possible urinary tract infection (UTI).2. R7's EMR documented diagnoses of urinary retention (lack of ability to urinate and empty the bladder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R7's Quarterly MDS, dated 12/12/25, recorded a BIMS score of 13 indicating intact cognition. R7 had no rejection of care during the observation period. R7 was dependent on staff for toileting hygiene, showers, and dressing. She had an indwelling catheter. R7's Care Plan, dated 02/28/25, directed staff to provide foley catheter care. Change the foley catheter as needed. Directed staff to observe catheter tubing for kinks and to keep the foley catheter below the level of the bladder. R7's Care Plan, revised date 01/11/26, staff instructed to maintain a16 Fr. 10 cc. Foley catheter temporarily placed to assist with decreased moisture to promote healing of pressure wound. R7's EMR listed the following orders: Indwelling catheter, 16Fr, 10 cc, change catheter and bag as needed for signs and symptoms of infection, obstruction or when the closed system has been compromised as needed for wound healing, dated 03/03/25. A Provider Progress Note, dated 12/29/25, documented the resident had a history of frequent UTI with resistant bacteria. During an observation and interview on 01/28/26 at 07:33 AM, R7 was in bed watching TV. The room smelled strongly of urine. Further observation revealed she had no securement device on the catheter tubing. R7 reported she had never had anything to hold her tubing down.During an observation on 01/29/26 at 09:07 AM, R7 was in bed with her eyes closed. There was a strong urine smell present in her room. Her catheter bag was not covered and there was no urine visible in the bag.3. R21's EMR recorded diagnoses of sepsis (a life-threatening systemic reaction which develops due to infections that cause inflammation throughout the entire body) and neuromuscular dysfunction of the bladder (a condition where nerve disease or injury disrupts signals between the brain and the bladder). R21's Quarterly MDS, dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175236	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hutchinson Operator, LLC	2301 N Severance Street Hutchinson, KS 67502

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/09/26, recorded a BIMS score of 15 indicating intact cognition. R21 had no rejection of care during the observation period. R21 was dependent on staff for toileting hygiene, and showers and required maximal/extensive staff assistance with personal hygiene. She had an indwelling catheter. R21's Care Plan, dated 10/09/24, directed staff to provide foley catheter care. Change the foley catheter as needed. Directed staff to observe catheter tubing for kinks and to keep the foley catheter below the level of the bladder.R21's EMR listed the following orders: Indwelling catheter, 16Fr, 10 cc, change catheter and bag as needed for signs and symptoms of infection, obstruction or when the closed system has been compromised as needed for wound healing dated 01/20/25.A Nursing Progress Note, dated 01/02/26 at 06:36 AM, documented R21 was admitted to the hospital with urosepsis (sepsis related to UTI).During an observation and interview on 01/27/26 at 09:09 AM, it was revealed R21's urine collection bag was not covered and was positioned towards the doorway of the room. CNA M knocked, entered the room, and reported he needed to cover the bag for dignity purposes. During an interview on 01/27/26 at 09:11 AM, R21 reported she has no anchor or securement device to keep the catheter in place and said she was lucky if she got catheter care. She reported staff did not provide the catheter care every day and she had to ask for her catheter to be cleaned. She was unsure why she had a catheter and said she thought it was because she was incontinent, and staff did not have the time to assist her.During an interview on 01/28/26 at 09:55 AM, CNA O reported she had not really seen a securement device for any residents foley catheter used at this facility. She reported all the foley catheter drainage bags should always be covered, and the catheter bag should not be placed on the floor.During an interview on 01/28/26 at 06:25 PM, Administrative Nurse E reported she expected staff to apply securement device to each resident foley catheter to prevent pulling or dislodgement. She also expected the staff to cover catheter drainage bags with a dignity bag.The facility's policy Indwelling Urinary Catheters, dated 05/2025, documented if the resident had an indwelling urinary catheter, the staff would cover the urine bag to provide privacy. The staff would ensure the catheter remained secure with a leg strap to reduce friction and movement at the insertion site.

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Hutchinson Operator, LLC	2301 N Severance Street Hutchinson, KS 67502

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 42 residents. The sample included 12 residents with five reviewed for immunizations. Based on record review and interview, the facility failed to provide education and obtain consent or informed declination for the pneumococcal (type of bacterial infection) vaccine for Resident (R) 1, R20 and R25. Findings included:- Review of R1's Immunization Record lacked documentation of education provided by the facility, regarding the risk verses benefits of pneumococcal vaccine administered on 10/11/22, since his entry on 08/29/19. Review of R20's Immunization Record lacked documentation of education provided by the facility regarding the risk verses benefits and/or the offer of pneumococcal vaccine since his entry on 09/25/25. Additionally, the documentation lacked indication of historical data of the resident's pneumovax status. Review of R25's Immunization Record lacked documentation of education provided by the facility, regarding the risk verses benefits and/or the offer of pneumococcal vaccine, since his entry on 04/06/23. Additionally, the documentation lacked indication of historical data of the resident's pneumococcal vaccine status. On 01/29/2026 at 11:05 AM, Administrative Nurse E confirmed the facility failed to provide the above residents with education regarding the risk verses the benefits for pneumococcal as they should to allow residents to make an informed decision regarding the pneumococcal vaccine. The facility policy titled F883, F884, F887 Vaccination of Residents including Influenza, Pneumococcal, and COVID-19, Reporting of documentation included residents will be offered pneumovax vaccinations. Prior to receiving vaccinations, the resident or legal representative will be provided with information and education regarding the benefits and potential side effects of the vaccinations. Provisions of such education shall be documented in the residents' medical record.

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	175236	A. Building B. Wing	01/29/2026

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Hutchinson Operator, LLC	2301 N Severance Street Hutchinson, KS 67502

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 42 residents. Based on observation and interview, the facility failed to provide housekeeping and maintenance services to ensure a safe and sanitary environment in the facility laundry. Findings included:- On 01/29/2026 at 10:31 AM, an inspection of the laundry with Housekeeping Staff/Maintenance Staff U revealed the following concerns: Three soiled laundry bins with an unsanitary, cracked top on the outer edge rim. The floor of the sorting room had paint missing, resulting in an unsanitary surface throughout the laundry room. The table used for folding clean laundry had two USB cables lying across the table surface where staff processed clean laundry. Four cardboard boxes sat directly on the floor and a tray carrier with chemicals was directly on the floor. Four uncovered pillows were stored under a table leaning in direct contact with the wall. There were four feet of missing baseboard at the junction of the soiled linen sorting room wall and floor. Broken and missing tile at the soiled laundry sorting room door transition tile missing at transition at tile floor. On 01/29/2026 at 10:31 AM, Housekeeping /Maintenance Staff U confirmed the above findings and agreed the laundry needed repairs to ensure a safe and sanitized area for staff to process the residents clothing and linen. The facility policy titled Storage Areas, Environmental Services, dated 10/2025, documentation included housekeeping and laundry department areas shall be maintained in a clean safe manner.