STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175246	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleville Healthcare and Rehabilitation Center	2626 Wesleyan Dr Belleville, KS 66935

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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 48 residents. The sample included 12 residents, with three residents reviewed for restorative nursing services. Based on observation, interview, and record review, the facility failed to provide restorative nursing services to prevent further decrease in range of motion (ROM) for Resident (R) 40's left hand, which had limited mobility. This deficient practice resulted in actual harm when R40 had a significant decrease in ROM to the left hand, could not mobilize her wheelchair without staff assistance, voiced concern that an orthopedic (pertaining to bones) surgeon would have to rebreak her hand to repair it, and voiced pain in her left hand at all times.Findings included:- R40's Electronic Medical Record (EMR) documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and traumatic subdural hematoma (SDH- a serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R40 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R40 required partial to moderate assistance with showering. The MDS documented R40 did not have any range of motion services with restorative nursing therapy during the look-back period. The MDS noted no functional limitation in ROM.The Functional Abilities Care Area Assessment (CAA), dated 11/18/24, documented the facility would address functional mobility in R40's care plan. The CAA documented staff were to assist R40 with her activities of daily living (ADL) as needed, anticipate R40's cares so her needs were met effectively. The CAA documented therapy services were to be used as needed to increase functional mobility.R40's Care Plan directed staff to know R40 was at risk for alteration in comfort due to decreased mobility, assess R40 for pain each shift, and report pain in a timely manner (11/13/24). The care plan documented R40 received restorative care for walking (08/12/25). The care plan lacked any other restorative discipline. The care plan documented R40 had an alteration in musculoskeletal status related to fractures (broken bones) at the base of the proximal phalanx (the bone in a finger closest the hand) of the fifth digit of the left hand, an acute displaced fracture of the hamate (a small triangular shaped bone in the wrist) of the left hand, and an acute fracture of the lateral radial styloid (the palpable bony projection on the outer side of the distal radius bone) of the left hand from a fall on 01/31/25. The goal in the care plan was for R40's fracture to heal and progress without any complications, and R40 would return to her prior level of function after the fractures healed. The care plan directed staff R40 wear a brace on her left arm until after the orthopedic follow-up (02/04/25).The Incident Note, dated 01/31/25 at 11:15 PM, documented staff assisted R40 outside in her wheelchair. While outside, R40 leaned forward and rolled out of her wheelchair onto the ground. Staff brought R40 back inside and noted a scrape on R40's left cheek and chin. R40 complained of left wrist pain and held her left wrist. Staff asked the resident to grip the nurse's hands and she could not do so with her left hand. Staff notified the local hospital of R40's pending transfer. The General Note, dated 02/01/25 at 11:39 AM, documented R40 returned from the local hospital and noted she sustained a fracture of her left wrist and pinky finger. The note stated R40 was to wear a brace at all times until seen by the orthopedic doctor. R40 (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 0688 Level of Harm - Actual harm Residents Affected - Few	received new orders for Norco (pain medication) and Metoprolol (blood pressure medication).The February 2025 Treatment Administration Record (TAR) documented R40 wore a brace at all times until the orthopedic surgeon could see her, with no refusals documented. This order discontinued on 02/24/25. The TAR documented a new order for a specialized brace to the resident's left wrist, which could be removed for ROM and hygiene, started 02/24/25 with no refusals documented.The Appointment Note, dated 02/18/25, documented due to sickness in the building and weather, R40's appointment with the orthopedic surgeon was moved to 02/24/25 at 10:45 AM.The Nurse's Note, dated 02/24/25, documented the resident returned from the orthopedic surgeon appointment with diagnoses of left distal radius (wrist) fracture and left small finger proximal phalanx (finger) fracture. Staff would apply a specialized brace to the resident's wrist and remove for ROM and hygiene. The resident required occupational therapy for gentle finger ROM for the next three weeks, and then could add gentle wrist ROM. Occupational therapy (OT) received a copy of the orders.The Occupational Therapy Evaluation and Plan of Treatment, dated 02/26/25, documented OT would see R40 one to five times a week for four weeks. The goals for R40 would be to increase the flexion (bending of a limb or joint) of her left wrist to 45 degrees to improve functional grasp/release skills. R40's prior level of flexion of her left wrist was 70 degrees, and the current level of flexion was 10 degrees. R40 would increase her left thumb flexion to 30 degrees to improve functional grasp/release skills. R40's prior level of function in her left thumb was 45 degrees, and her current level of function was 0 degrees. R40 would increase her left ring finger flexion to 75 degrees to improve functional grasp/release skills. R40's prior level of flexion to the left ring finger was 90 degrees, and her current level of flexion was 0 degrees. R40 would increase her pinky finger flexion to 75 degrees to improve her functional grasp/release skills. R40's prior level of function in her pinky finger was 90 degrees, and her current level of function was 0 degrees. The evaluation noted R40 presented with impairments in dexterity, fine motor coordination, mobility, and strength. The March 2025 TAR documented R40 wore her specialized brace daily, with no refusals. The order was discontinued on 03/24/25.The Therapy Screen Note, dated 04/21/25, documented R40 had a fall on 04/14/25. R40 continued to receive occupational therapy for strengthening and ROM on the left hand following a fracture.The Occupational Therapy Discharge Summary, dated 04/30/25, documented R40 was discontinued from therapy due to R40 having exhausted/used all of her benefits. R40's left wrist flexion prior to her wrist fracture was 70 degrees, and her level of function at the time of discharge was 45 degrees. R40's left thumb flexion prior to her injury was 45 degrees, and her current level of function was 35 degrees. The left ring finger's prior level of flexion was 90 degrees, with a current level of flexion at 70 degrees. The left pinky finger's prior level of function was 90 degrees, and her current level of flexion was 70 degrees. Occupational therapy recommended R40 for a restorative ROM program.The Range of Motion Task for May 2025 documented the resident would receive gentle assisted active ROM four to seven times a week to her left wrist and fingers. Documentation revealed staff performed gentle assisted ROM 13 days out of 31 days for fifteen minutes each.The Range of Motion Task for June 2025 documented the resident would receive gentle assisted active ROM four to seven times a week to her left wrist and fingers. Documentation revealed staff performed gentle assisted ROM 11 days out of 30 days for fifteen to 30 minutes each.The Range of Motion Task for July 2025 documented the resident would receive gentle assisted active ROM four to seven times a week to her left wrist and fingers. Documentation revealed staff performed gentle assisted ROM two days out of 31 days for thirty minutes each.The EMR lacked documentation staff performed ROM on R40 in August 2025, and the restorative aide discontinued the task on 08/05/25.On 09/14/25 at 10:30 AM, R40 sat in her wheelchair in her room. R40's left hand was contracted. R40 rubbed her left hand with her right hand as she was spoke. R40 stated she fell out of her wheelchair when she was outside smoking and broke her left hand. R40 stated her hand was frozen and she could not move her fingers. R40 stated she thought the doctor was going to have to re-break her hand and fingers to get her hand back to normal. R40 stated her left hand hurt all the time.On 09/15/25 at 01:30 PM, R40 sat in the (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	living area putting a puzzle together. R40 had her left hand wrapped up in a blanket. R40 stated she could not do much with her left hand, it was cold, hurt all of the time, and that is why she kept that hand covered up with her blanket. On 09/16/25 at 11:00 AM, R40 stated she could not use her hands to self-propel in her wheelchair because her left hand would not work moving the wheel. R40 again stated the doctor was going to have to re-break her hand to get it back to normal.On 09/15/25 at 02:30 PM, Director of Therapy GG stated she discontinued R40 from therapy because her left hand was functional. She placed R40 on a restorative range of motion program for her left hand. Director of Therapy GG stated she was unaware R40 was no longer on a restorative program for ROM.On 09/15/25 at 03:30 PM, Administrative Nurse D stated the reason R40 had the contracture of her left hand was because she refused to wear her arm braces the way she was supposed to. Administrative Nurse D verified the months and days restorative therapy were and were not provided to R40. Administrative Nurse D did not know why restorative ROM activities were discontinued for R40.The facility's undated Restorative Nursing Programs Policy documented the policy of the facility is to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Physical functioning of all residents will be assessed in accordance with the facility's assessment protocols. The interdisciplinary team, with the support and guidance from the physician, will ensure the ongoing review, evaluation, and decision-making regarding the services needed to maintain or improve residents' abilities in accordance with the residents' comprehensive assessment, goals, and preferences. Nursing personnel are trained on basic, or maintenance, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight. All residents would receive maintenance restorative nursing services as needed by certified nursing assistants.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility identified a census of 48 residents. The sample included 12 residents. Based on observations, interviews, and record review, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during the day-to-day operations and emergencies. Findings included:- On 09/15/25, Administrative Nurse D provided a Facility Assessment updated 04/28/25. A review of the assessment revealed the following:The assessment identified the required staffing needs per day but failed to identify the specific staffing needs by shift for the weekends.The assessment failed to identify the resident's acuity for care needs.The assessment failed to provide a detailed emergency staffing plan in the event of emergent situations.On 09/15/25 at 03:00 PM, Consultant HH stated the facility assessment that had previously been given to the survey team was not the correct facility assessment. Consultant HH gave a new facility assessment, stating, This is the actual facility assessment. Consultant HH stated Administrative Nurse D filled out the facility assessment, and everything she typed in the assessment would be in bold black print.On 09/15/25 at 03:15 PM, Administrative Nurse D stated she did not feel the facility had low weekend staffing, and the facility assessment had daily nursing hours that included the increased staff presence during the weekdays.On 09/16/25 at 10:00 AM, Administrative Staff A verified the facility assessment did not have a detailed emergency staffing plan.The facility's undated Facility Assessment and Procedure Policy documented it was the facility's policy to conduct and document a facility-wide assessment to determine the resources necessary to care for its residents during the day-to-day operations (including nights and weekends) and during emergencies. The facility would review and/or revise the assessment as necessary and as required by law.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 48 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the residents who resided in the facility and received meals from the facility kitchen. Findings included:- On 09/15/25 at 11:00 AM, a review of the noon meal consisted of chicken breast with seasoned tomatoes, squash, fortified mashed potatoes, buttered noodles, and cake.On 09/15/25 at 11:30 AM, observation revealed Dietary Staff (DS) BB in the kitchen preparing the noon meal. On 09/15/25 at 10:50 AM, DS BB verified she was not a Certified Dietary Manager (CDM). DS BB stated she had enrolled and started the dietary certification classes.On 09/16/25 at 10:07 AM, Administrative Nurse D verified DS BB had no dietary manager certification but had enrolled and started the dietary certification classes. The facility's Dining Services Manager Roles and Responsibilities Policy, undated, documented the following qualifications of the dining services manager: should be considered: Certified Dietary Manager (CDM), Certified Food Protection Professional (CFPP) credential, or Certified Food Service Manager; or National certification for food service management and safety from a national certifying body; or Associate's or higher degree in food service management or hospitality from an accredited institution of higher learning. The policy documented that the facility would provide orientation, training, supervision, and evaluation of all dining services staff.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. The facility had a census of 48 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide an adequate number of dietary staff to serve the residents, who received their meals in the dining room.Findings included:- On 09/15/25 at 11:45 AM, observation in the kitchen revealed Dietary Manager (DM) BB had tempered the food items on the steam table and was ready to serve the residents' food. Observation revealed several residents sat at dining room tables waiting for their noon meal.On 09/15/25 at 12:15 PM, staff came to the serving window and notified DM BB that they were ready to serve residents' food. Observation revealed DM BB completed serving at 01:00 PM.On 09/15/25 at 11:45 AM, DM BB stated the scheduled time for the noon meal was 11:30 AM. DM BB stated she could not start serving residents in the dining room their noon meal until staff were available in the dining room to serve food. DM BB stated she only had one dietary aide who was responsible for placing drinks on trays and other items needed that were not on the steam table. DM BB stated the dietary aide was also responsible for dishwashing.On 09/16/25 at 12:55 PM, observation revealed Resident (R) 31 and R17 had not received their noon room meal trays.On 09/16/25 at 01:00 PM, Administrative Nurse D stated the noon meal should be served in a timely manner, and she was unaware the dietary department was short-staffed. Administrative Nurse D stated DM BB was in charge of hiring her staff. Administrative Nurse D stated that Administrative Staff A and she would be helping DM BB in the future to hire staff.Upon request, the facility failed to provide a policy regarding dietary staff serving time.

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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. The facility had a census of 48 residents. Based on observation, interview, and record review, the facility failed to cover clean linen and clothing when transporting through the facility to prevent potential contamination, which could lead to infection. Findings included: - On 09/14/25 at 12:30 PM, Housekeeping Staff U took an uncovered laundry cart with clean resident clothing hanging up and linens on the shelf through the facility to the southeast hall.On 09/15/25 at 11:55 AM, Housekeeping Staff V verified staff were to cover residents' personal clothing when transporting it to their room. On 09/15/25 at 01:00 PM, Administrative Nurse D staff should cover the residents' clothing when taking through the hall to their room. The facility's Handling Clean Linen policy, dated 06/2025, stated linen could become contaminated from environmental contaminants. The policy stated clean linens should be delivered to resident care units on covered carts with the covers down.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility had a census of 48 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility staff failed to treat Resident (R) 16 with dignity at the dining table when Certified Nurse Aide (CNA) P stated, Here is your bib, and placed a clothing protector on R16. Findings included:- On 09/14/25 at 11:32 AM, during the noon meal, R16 sat at the dining room table. CNA P brought a clothing protector to her table, stated, Here is your bib, and placed the clothing protector on R16.On 09/16/25 at 11:18 AM, Administrative Nurse D stated she would expect staff to offer a resident a clothing protector at meals, and staff should not call it a bib.The facility's Promoting/Maintaining Resident Dignity Policy, revised 01/01/20, documented that it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity, as well as care for each resident in a manner and in an environment that maintains or enhances the resident's quality of life by recognizing each resident's individuality.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. The facility identified a census of 48 residents. The sample included 12 residents, with three residents reviewed for accommodation of needs. Based on record review, observation, and interview, the facility failed to accommodate Resident (R) 31's needs when they failed to ensure R31's walker could safely fit into the bathroom after her admission to the facility. This deficient practice placed R31 at risk for falls as she would leave her walker outside the bathroom door and furniture walk (using the sink for support) in the bathroom to use the toilet and wash her hands.Findings included:- R31's Electronic Medical Record (EMR) documented diagnoses of cellulitis (skin infection caused by bacteria) of the lower extremities, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), polyneuropathy (a general term for peripheral nervous system disorders that impact nerve function in multiple areas of the body), and hypertension (high blood pressure).The admission Minimum Data Set, dated 09/09/25, documented R31 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R31 required supervision/touching or set-up help for all activities of daily living (ADL). The MDS documented R31 used a walker for locomotion. The MDS documented R31 received scheduled pain medication, as-needed (PRN) pain medication. R31 frequently had pain, which occasionally affected her sleep and occasionally affected her day-to-day activities. R31 rated her pain at seven on a pain scale of zero to 10.The Functional Abilities Care Area Assessment (CAA), dated 09/09/25, documented R31 required supervision or light touch for ADLs. The CAA documented R31 used a walker, had weakness, and polyneuropathy, which could impair sensation and balance. The CAA documented R31 had chronic pain with complaints of pain daily. The CAA documented R31 took medications that could lead to dizziness and increase her risk for falls.The Pain CAA, dated 09/09/25, documented R31 routinely reported symptoms of pain and had several diagnoses that could cause pain. Frequent and daily pain should be care planned for R31 and should focus on prevention, as well as symptom management.R31's Care Plan, dated 09/04/25, documented R31 required moderate/partial assistance with toileting hygiene and bathing. The care plan documented for all other ADLs, R31 required supervision or was independent (09/04/25). The care plan documented R31 was incontinent of urine and occasionally incontinent of bowel (09/04/25). The care plan directed staff to assess R31 for pain each shift and treat reported pain in a timely manner (09/04/25). The care plan documented R31 was at risk for falls and directed staff to anticipate and meet R31's needs, be sure R31's call light was in reach, and respond promptly to all requests (09/04/25).The EMR lacked nursing notes regarding the accommodation of needs or pain.On 09/14/25 at 09:30 AM, R31 stated she had been in the facility for almost two weeks, and she was very disappointed in the care she had received so far. R31 stated she did not feel safe going to the bathroom because her walker would not fit into the bathroom, and she had to leave her walker by the door and use the sink and the door frame to get into the bathroom to get to the toilet to urinate.On 09/14/25 at 09:45 AM, observation revealed R31 used her walker to walk to the bathroom and then tried to get her walker into the bathroom, but the walker would not fit into the bathroom.On 09/15/25 at 09:30 AM, observation revealed R31 had been moved into a different room up the hall from her previous room. R31's walker was observed not to fit into the bathroom. R31 stated she had been moved to the new room last night so the floor in her room could be redone. R31 stated the new bathroom was even worse than the first bathroom, and she had an even harder time getting into the new bathroom. R31 stated her roommate could not get into the bathroom safely.On 09/16/25 at 01:00 PM, observation revealed R31 in a different room on a different hall. R31 stated her new bathroom was much bigger, her walker fit into it, and she felt safe going to the bathroom.On 09/15/25 at 03:00 PM, Administrative Staff A went to R31's room and was shown how R31's walker would not fit into the old room's bathroom, as well as the new room's bathroom. R31 stated she did not feel safe going to the bathroom. Administrative Staff A verified that neither bathroom was safe for R31 to use. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrative Staff A stated he would figure something out.The facility's undated Accommodation of Needs Policy documented the facility would treat each resident with dignity and respect and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident except when the health and safety of the individual or other residents would be endangered. The facility will make reasonable accommodations to individualize the resident's physical environment, including their personal bathroom, bedroom, and common living areas within the facility.

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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 48 residents. The sample included 12 residents, with one reviewed for hospitalization. Based on observation, interview, and record review, the facility failed to provide a bed hold notice, as required, to Resident (R) 4 or their representative upon discharge from the facility. Findings included:- R4's Electronic Medical Record documented diagnoses of sepsis (life-threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), seizures (violent involuntary series of contractions of a group of muscles), and a history of sudden cardiac arrest.R4?s Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R4 was dependent on staff for all activities of daily living. R4's medical record documented she had been discharged to a hospital on the following dates:On 03/22/25 and readmitted to the facility on [DATE]. On 04/02/25 and readmitted to the facility on [DATE].The facility lacked evidence R4 or her representative was provided a bed hold notice at the time of each discharge. On 09/15/25 at 07:47 AM, R4 laid in bed with the head of the bed elevated. She had a gastric tube feeding running at 35 milliliters per hour. On 09/16/25 at 08:25 AM, Consultant HH verified the facility had not provided the bed hold notices for two of R4's hospital stays. The facility's Transfer and Discharge policy, dated 02/01/20, stated staff were to provide a notice of the resident's bed hold policy to the resident and their representative within 24 hours of the transfer.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleville Healthcare and Rehabilitation Center	2626 Wesleyan Dr Belleville, KS 66935

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 48 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to review or revise Resident (R) 5's care plan with new effective interventions after each fall.Findings included: - R5?s Electronic Medical Record documented diagnoses of anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty, and irrational fear), dementia (progressive mental disorder characterized by failing memory, and confusion), and cerebral infarction (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R5?s admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented R5 was dependent on staff for activities of daily living, including mobility, and had no falls since admission.R5?s Fall Care Area Assessment (CAA), dated 06/06/25, stated R5 was at risk for falls and staff were to anticipate and meet the resident's care needs so that the resident did not attempt to unsafely perform activities of daily living (ADL) cares without staff assistance. The CAA documented therapy services were to be available to help increase functional mobility and reduce fall risk.R5?s Care Plan, documented fall prevention interventions were to educate the resident on how the call light works, date initiated 05/31/25. The care plan directed staff to offer the resident to lie down following meals, date initiated 06/01/25. The care plan directed R5's bed to be repositioned with the right side against the wall per the resident and family request to aid in positioning safety, date initiated 06/05/25. The care plan directed staff to increase monitoring during periods of increased confusion, date initiated 07/11/25. The care plan directed staff to place his water cup within reach, date initiated 08/07/25. The care plan directed that Dycem (non-slip material) be placed in his chair, date initiated 08/11/25. The care plan documented R5 would have labs to evaluate for acute infection, date initiated 08/31/25.The Fall Risk Assessment, dated 05/30/25, documented R5 was at high risk for falling, had a history of falls and was forgetful of own safety limits.The Fall Note, dated 05/31/25 at 12:51 PM, documented staff found R5 on the floor by his bed. He stated he was looking for his call light, which was lying across his chest. The Fall Note, dated 06/01/25 at 02:15 PM, documented R5 was in his wheelchair in the lobby area, and the nurse was looking around the lobby to check on the residents who were sitting in there. R5 leaned forward in his wheelchair, fell face forward, and had no injuries at this time. The Fall Note, dated 06/05/25 at 08:51 PM, staff found R5 lying on the right side of his bed on the floor. The bed was in the lowest position, and no injuries seen at this time. His bed was repositioned so that the right side of it was placed next to the wall, and it was in the lowest position. Staff were educated about the bed placement and that it needed to be in the lowest position when he was in bed. The Fall Note, dated 06/06/25 at 12:02 AM, documented R5 pulled the call light cord out of the wall, stating, It gets the staff in faster. Upon entering the room, staff noted that R5 had just sat on the floor and told the nurse that he was trying to get up to get something to eat. While staff attempted to help R5 back into his bed, he laid down on the floor and told staff that he fell out of his bed. Three staff members were in his room when he did this.The Fall Note, dated 07/11/25 at 03:43 PM, documented at 10:15 AM R5 was observed lying on the floor next to his bed face down. The fall reopened a skin tear on his left forearm, which was cleaned, and a bandage was applied. R5 said that he was Getting his car keys and going to his car and leaving. The note documented visual monitoring provided throughout the day. The Fall Note, dated 07/14/25 at 09:18 AM, documented R5 was in the dining room and sliding out of his chair. Staff had to assist him multiple times to sit up in his wheelchair. R5 then slid onto the floor under the dining room table, with no injuries. No intervention to prevent further falls was documented after the fall. The Fall Note, dated 08/07/25 at 08:01 PM, documented R5's roommate informed the nurse and another staff member that R5 sat on (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor beside his bed, with his left hand on the mobility bar. R5 said that he was trying to pick up his water cup as it had fallen to the floor. His bed was in the low position, and his call light had been pulled out of the wall. Prior to this, he had been lying in bed with it in the low position and his call light in reach. No injuries seen at this time. Staff placed a fall mat by his bed for the intervention. (after three prior falls from the bed).The Fall Note, dated 08/10/25 at 04:26 PM, documented another resident had notified the nurse that R5 had slid out of his chair. Staff found R5 lying in front of his wheelchair with skin tears to his right upper arm. Staff turned R5's wheelchair to face the staff in the lounge. The 08/11/25 intervention was to add a non-slip material to his wheelchair seat. (after the second fall, where R5 slid out of his wheelchair).The Fall Note, dated 08/23/25 at 02:42 AM, staff found R5 in the lounge, lying on his back on the floor. Staff applied Band-Aids to his elbows. R5 stated he wanted to go to bed. No new intervention noted. The Fall Note, dated 08/30/25 at 06:15 PM, documented staff found R5 lying on the floor in front of his wheelchair. R5 stated he slipped out and was going to crawl to his room. R5 had a skin tear on his right elbow. On 08/31/25, the intervention was to obtain lab work. The 09/14/25 Therapy Screen stated R5 had a fall on 08/30/25. R5 had been discharged from therapy due to decreased participation and refusals. The screen stated R5 was noncompliant with interventions and had decreased safety awareness. Therapy requested the physician's orders for therapy. On 09/15/25 at 07:40 AM, R5 sat in his wheelchair in the facility's living room with his eyes closed. Staff were within sight and assisting other residents to the dining room. On 09/15/25 at 07:53 AM, Licensed Nurse (LN) H stated R5 was trying to get out of bed earlier this morning, so staff assisted him up at that time. She stated he had not had breakfast yet. On 09/16/25 at 08:09 AM, Administrative Nurse D verified that obtaining lab work was not an immediate fall prevention intervention. She verified the interventions should be directed toward preventing further falls. The facility's Care Plan Revisions Upon Status Change policy, dated 02/01/20, stated the comprehensive care plan would be reviewed and revised as necessary when a resident experienced a status change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. The facility identified a census of 48 residents. The sample included 12 residents, with three residents reviewed for Activities of Daily Living (ADL). Based on record review, observation, and interview, the facility failed to ensure Resident (R) 31 was showered/bathed according to her preference, twice a week. Findings included:- R31's Electronic Medical Record (EMR) documented diagnoses of cellulitis (skin infection caused by bacteria) of the lower extremities, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), polyneuropathy (a general term for peripheral nervous system disorders that impact nerve function in multiple areas of the body), and hypertension (high blood pressure).The admission Minimum Data Set (MDS), dated 09/09/25, documented R31 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R31 required supervision/touching or set-up help for all ADLs. The MDS documented R31 used a walker for locomotion. The MDS documented R31 received scheduled pain medication, as needed pain medication. R31 frequently had pain, which occasionally affected her sleep and occasionally affected her day-to-day activities. R31 rated her pain at a seven on a pain scale of zero to 10.The Functional Abilities Care Area Assessment (CAA), dated 09/09/25, documented R31 required supervision or light touch for ADLs. The CAA documented R31 used a walker, had weakness, and polyneuropathy, which could impair sensation and balance. The CAA documented R31 had chronic pain with complaints of pain daily. The CAA documented R31 took medications that could lead to dizziness and increase her risk for falls.The Pain CAA, dated 09/09/25, documented R31 routinely reported symptoms of pain and had several diagnoses that could cause pain. Frequent and daily pain should be care planned for R31 and should focus on prevention as well as symptom management.R31's Care Plan, dated 09/04/25, documented R31 required moderate/partial assistance with toileting hygiene and bathing. The care plan documented for all other ADLs, R31 required supervision or was independent (09/04/25). The care plan documented R31 was incontinent of urine and occasionally incontinent of bowel (09/04/25). The care plan directed staff to assess R31 for pain each shift and treat reported pain in a timely manner (09/04/25). The care plan documented R31 was at risk for falls and directed staff to anticipate and meet R31's needs, be sure R31's call light was in reach, and respond promptly to all requests (09/04/25).The EMR documented R31 had one shower in the twelve days she had been in the facility.On 09/14/25 at 09:30 AM, observation revealed R31 had unclean, unkempt hair. R31 had a distinct odor of urine about her. R31 stated she had not had but one shower since she had been in the facility, and she felt dirty, unclean, and felt like she smelled.On 09/15/25 at 010:00 AM, Licensed Nurse (LN) H stated she expected the residents to receive their showers per their preference.On 09/15/25 at 03:30 PM, Administrative Nurse D stated she expected staff to shower residents more than once every twelve days. The facility's Activity of Daily Living Policy, dated 08/01/19, documented the facility would ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. A resident who is unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility would maintain the individual objectives of the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 48 residents. The sample included 12 residents, with five residents reviewed for falls, supervision, and safety. Based on record review, observation, and interview, the facility failed to provide a safe environment with appropriate supervision to prevent falls for Resident (R) 46 and R5.Findings included:- R46's Electronic Medical Record (EMR) documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), abnormalities of gait and mobility, and a chronic non-pressure wound to the right foot. The Quarterly Minimum Data Set (MDS), dated 07/29/25, documented R46 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R46 required partial to moderate assistance for donning and doffing footwear, lower body dressing, bathing, and toileting. R46 required supervision/touching assistance for shower transfer. The MDS documented R46 had one fall with minor injury during the lookback period. The Functional Abilities Care Area Assessment (CAA), dated 04/28/25, documented staff were to assist R46 with activities of daily living (ADL) cares as needed, anticipating cares to that her care needs were met effectively. The Falls CAA, dated 04/28/25, documented staff were to anticipate and meet R46's care needs so that R46 did not attempt to unsafely perform ADL cares without staff assistance. R46's Care Plan documented R46 was at risk for falls due to impaired mobility and muscle weakness (10/25/24). The care plan documented R46 was to be non-weight bearing to her right foot due to a chronic ulcer on the bottom of her foot. The care plan documented staff were directed to use extra safety measures when the shower floor was wet (07/29/25). The care plan documented R46 required assistance with transferring due to being non-weight-bearing to her right lower extremity (04/24/25). The care plan directed staff R46 required one staff assist for bathing. The care plan lacked any interventions related to R46 refusing help from staff with transfers or help in the shower. The Incident Note, dated 07/29/25, documented the Certified Nurse's Aide (CNA) called the nurse to the west shower. On entering the shower house, observed R46 lying on the floor in front of her wheelchair. R46 had been standing in front of the shower chair for a bit and then transferred herself to the wheelchair and when R46 moved her left foot slid out from underneath her on the wet floor, and she fell forward. R46 fell to her knees and then went forward and caught herself on the wheelchair with the inner sides of her elbows. R46's head was lying on the seat of her wheelchair. An assessment was done, R46 had bruising on her bilateral inner elbows and abrasions on her bilateral knees. The floor was dried up, and then multiple staff members assisted R46 up from the floor and into her wheelchair. The Fall Investigation, dated 07/29/25, documented the reason for the fall was the exhaust fan was off, so the humidity was seen on the floor, possibly causing a slick surface. The intervention for the fall was for staff to use extra safety measures when the floor is wet/humid. On 07/14/25 at 11:30 AM, observation revealed R46 sat in her electric recliner watching out the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	window.R46 stated that a couple of months ago, she had fallen in the shower because the staff would not help her transfer. R46 stated she is non-weight-bearing on her right foot because of an ulcer, and it is difficult for her to transfer by herself in the shower. R46 stated she knew what her care plan said about transfer and showering. R46 stated she never received any help from staff in the shower area. R46 stated she feels like the lack of staff support caused her to fall. On 09/16/25 at 01:30 PM, CNA O stated she had just gotten done giving R46 a shower. CNA O stated she only observed R46 showering and did not help her with anything in the shower. CNA O stated she did not know if R46 had ever refused help transferring or not. On 09/15/25 at 03:30 PM, Administrative Nurse D stated R46 refused all staff assistance with transferring or bathing. Administrative Nurse D stated the only thing R46 might ask for help with was toileting hygiene. Administrative Nurse D stated the facility could not help that R46 refused help. The facility's Accident and Supervision Policy, dated 02/01/2020, documented the resident environment would remain as free from accident hazards as possible and each resident would receive adequate supervision and assistive devices to prevent accidents. This included: identifying hazards and risks, evaluating and analyzing hazards and risks, interventions to reduce hazards and risks, and monitoring for effectiveness - R5's Electronic Medical Record documented diagnoses of anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty, and irrational fear), dementia (progressive mental disorder characterized by failing memory, and confusion), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R5's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented R5 was dependent on staff for activities of daily living, including mobility, and had no falls since admission. R5's Fall Care Area Assessment (CAA), dated 06/06/25, stated R5 was at risk for falls and staff were to anticipate and meet the resident's care needs so that the resident does not attempt to unsafely perform activities of daily living (ADL) cares without staff assistance. The CAA documented therapy services were to be available to help increase functional mobility and reduce fall risk. R5's Care Plan, dated 06/03/25, documented fall prevention interventions were to educate the resident on how the call light works, date initiated 05/31/25. The care plan documented to offer the resident to lie down following meals, date initiated 06/01/25. The care plan directed R5's bed to be repositioned with the right side against the wall per the resident and family request to aid in positioning safety, date initiated 06/05/25. The care plan directed staff to increase monitoring during periods of increased confusion, date initiated 07/11/25. The care plan directed staff to place his water cup within reach, date initiated 08/07/25. The care plan documented Dycem (non-slip material) to be placed in his chair, date initiated 08/11/25. The care plan documented R5 to have labs to evaluate for acute infection, date initiated 08/31/25. The Fall Risk Assessment, dated 05/30/25, documented R5 was at high risk for falling, had a history of falls, and was forgetful of his own safety limits. The Fall Note, dated 05/31/25 at 12:51 PM, documented staff found R5 on the floor by his bed. He (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he was looking for his call light, which was lying across his chest. The Fall Note, dated 06/01/25 at 02:15 PM, documented R5 was in his wheelchair in the lobby area, and the nurse was looking around the lobby to check on the residents who were sitting in there. R5 leaned forward in his wheelchair, fell face forward, and had no injuries at this time. The Fall Note, dated 06/05/25 at 08:51 PM, staff found R5 lying on the right side of his bed on the floor. The bed was in the lowest position, and no injuries were seen at this time. His bed was repositioned so that the right side of it was placed next to the wall, and it was in the lowest position. Staff were educated about the bed placement and that it needed to be in the lowest position when he was in bed. The Fall Note, dated 06/06/25 at 12:02 AM, documented R5 pulled the call light cord out of the wall, stating, It gets the staff in faster. Upon entering the room, staff noted that R5 had just sat on the floor and told the nurse that he was trying to get up to get something to eat. While staff attempted to help R5 back into his bed, he laid down on the floor and told staff that he fell out of his bed. Three staff members were in his room when he did this. The Fall Note, dated 07/11/25 at 03:43 PM, documented at 10:15 AM R5 was observed lying on the floor next to his bed face down. The fall reopened a skin tear on his left forearm, which was cleaned, and a bandage was applied. The resident said that he was Getting his car keys and going to his car and leaving. The note documented visual monitoring provided throughout the day. The Fall Note, dated 07/14/25 at 09:18 AM, documented R5 was in the dining room and sliding out of his chair. Staff had to assist him multiple times to sit up in his wheelchair. R5 then slid onto the floor under the dining room table, with no injuries. No intervention to prevent further falls was documented after the fall. The Fall Note, dated 08/07/25 at 08:01 PM, documented R5's roommate informed the nurse and another staff member that R5 was sitting on the floor beside his bed, with his left hand on the mobility bar. R5 said that he was trying to pick up his water cup as it had fallen to the floor. His bed was in the low position, and his call light had been pulled out of the wall. Prior to this, he had been lying in bed with it in the low position and his call light in reach. No injuries seen at this time. Staff placed a fall mat by his bed for the intervention. (after three prior falls from the bed). The Fall Note, dated 08/10/25 at 04:26 PM, documented another resident had notified the nurse that R5 had slid out of his chair. Staff found R5 lying in front of his wheelchair with skin tears to his right upper arm. Staff turned R5's wheelchair to face the staff in the lounge. The 08/11/25 intervention was to add a non-slip material to his wheelchair seat. (after the second fall where R5 slid out of his wheelchair). The Fall Note, dated 08/23/25 at 02:42 AM, staff found R5 in the lounge, lying on his back on the floor. Staff applied Band-Aids to his elbows. R5 stated he wanted to go to bed. No new intervention noted. The Fall Note, dated 08/30/25 at 06:15 PM, documented staff found R5 lying on the floor in front of his wheelchair. R5 stated he slipped out and was going to crawl to his room. R5 had a skin tear on his right elbow. On 08/31/25, the intervention was to obtain lab work. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 09/14/25 Therapy Screen stated R5 had a fall on 08/30/25. R5 had been discharged from therapy due to decreased participation and refusals. The screen stated R5 was noncompliant with interventions and had decreased safety awareness. Therapy requested the physician's orders for therapy. On 09/15/25 at 07:40 AM, R5 sat in his wheelchair in the facility's living room with his eyes closed. Staff were within sight and assisting other residents to the dining room. On 09/15/25 at 07:53 AM, Licensed Nurse (LN) H stated R5 was trying to get out of bed earlier this morning, so staff assisted him up at that time. She stated he had not had breakfast yet. On 09/16/25 at 08:09 AM, Administrative Nurse D verified that obtaining lab work was not an immediate fall prevention intervention. She verified the interventions should be directed toward preventing further falls. The facility's Accidents and Supervision policy, dated 02/01/20, stated both facility-centered and resident-directed approaches include evaluating hazard and accident risk, including prior accidents, analyzing potential causes, and identifying or developing interventions. The policy stated supervision was an intervention of mitigating accident risk, and the facility would provide adequate supervision to prevent accidents.