STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview, and record review, the facility failed to provide the services of a full-time Certified Dietary Manager (CDM) for the residents who resided in the facility and received their meals from the kitchen. Findings included: - On 05/20/26 at 11:00 AM, Dietary Staff BB verified she was the Certified Dietary Manager (CDM) for the two facility kitchens but continued to work at another facility as well.During an interview on 05/21/26 at 09:35 AM, Administrative Staff A stated there should be a full-time CDM on site, and this was the expected transition for Dietary Staff BB. Administrative Staff A verified there should be a qualified dietician or other clinically qualified nutrition professional working full-time in the facility, to oversee the kitchen staff and dietary needs of the residents.During an interview on 05/21/26 at 11:05 AM, Consultant GG verified she was overseeing seven facilities kitchens and currently visits this facility on Fridays, then verified that neither she nor the CDM are working over 35 hours a week at the current facility.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure effective sanitizing of dishes when the sanitizer did not reach 120 degrees Fahrenheit, in one of the facility's two kitchens. Findings included:- During an observation on 05/20/26 at 12:15 PM, Dietary Staff EE ran a cycle of glassware through the sanitizer, in the secondary kitchen, and verified the temperature was 111 degrees Fahrenheit (F). During an interview on 05/20/26 at 12:30 PM, Maintenance Staff U confirmed the temperature on the sanitizer should be 120 degrees F. On 05/20/26 at 03:00 PM, Maintenance Staff U stated the temperature on the sanitizer was adjusted to 120 degrees Fahrenheit. The facility's undated Dietary Services Leadership & Shared CDM Policy stated residents are to receive safe, sanitary, and nutritionally adequate meals in accordance with physician orders, resident preferences and regulatory requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement adequate infection control practices when staff failed to perform hand hygiene and failed to sanitize shared equipment. Findings included:- On 05/20/2026 at 01:25 PM, an observation revealed Certified Nurse Aide (CNA) P and CNA N used a Hoyer lift (full body mechanical lift) for Resident (R) 35 who was on 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 transferred the resident from the wheelchair to the bed to change the resident's soiled brief. CNA P and CNA N washed their hands and applied personal protective equipment (PPE- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses before transferring and changing resident). CNA P and CNA N removed the soiled brief and applied a clean brief without changing gloves and performing hand hygiene. The two CNA staff then removed their PPE and placed it in the trash.On 05/20/2026 at 01:35 PM, an observation revealed CNA P and CNA N removed the Hoyer lift from R35's room and took it to R29's room across the hall without cleaning the lift. CNA P and CNA N used the unsanitary Hoyer lift to transfer R29 to the bed from the resident's wheelchair. On 05/20/2026 at 01:50 PM, an observation revealed CNA N removed the Hoyer lift from R29's room and placed it in the clean storage area with the other Hoyer lift without cleaning it. During an interview on 05/20/2026 at 02:04 PM, CNA P stated that dayshift does not clean the Hoyer lifts after resident use and only night shift was responsible for cleaning the equipment. CNA P indicated the Hoyer would be cleaned later that night.During an interview on 05/20/2026 at 02:10 PM, Licensed Nurse (LN) G stated that staff was supposed to clean the Hoyer lift after each resident use, and the night shift staff was responsible for deep cleaning the Hoyer lift. LN G went down to the clean storage area and cleaned the Hoyer lifts.During an interview on 05/20/2026 at 02:17 PM, Administrative Nurse E stated that the Hoyer lift was to be cleaned after each resident use and was to be deep cleaned by the night shift staff. Administrative Nurse E said the day shift staff had been educated on cleaning the Hoyer lift after each resident use.The facility's undated policy Equipment Cleaning Disinfection Policy documented that resident care equipment shall be cleaned and disinfected between resident use and whenever visibly soiled, contaminated, or as indicated by manufacturer instructions, facility infection prevention protocols, or applicable regulatory requirements.The facility's undated policy Enhanced Barrier Precautions documented the facility followed recommendations and guidance from the Centers for Disease Control to keep all residents safe from Healthcare Acquired Infections (infections that residents acquire while receiving medical treatment in a healthcare facility).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 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. Based on observation, interview, and record review, the facility failed to inform Resident (R) 5 or her representative about the risk and benefits of taking an antidepressant (a class of medications used to treat mood disorders).Findings included:- R5's Electronic Medical Record (EMR) revealed the following diagnoses: major depressive disorder (major mood disorder that causes persistent feelings of sadness).R5's 06/10/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R5 took a diuretic (a medication to promote the formation and excretion of urine), opioid (a class of controlled drugs used to treat pain), hypoglycemic (a type of medication to treat high blood glucose levels), and an anticonvulsant.R5's Falls Care Area Assessment (CAA) documented R5 received pain medications and diabetic medications.R5's Psychotropic Drug Use CAA was not triggered.R5's Care Plan documented R5 took an antidepressant for a diagnosis of major depressive disorder to improve functioning and reduce symptoms on 03/16/26.R5's Physician's Orders documented an order for sertraline 50 milligrams mg every evening, ordered on 05/29/25.R5's EMR had a Consent for Use of Psychotropic Medication dated 03/16/26. The uncompleted assessment documented R5 took sertraline 50mg for depression. The consent was unsigned.R5's EMR showed no indication that R5 or the representative was notified of the medication including the risk verses benefits or potential side effects of the medication.On 05/21/26 at 08:26 AM, R5 sat in her recliner watching television. R5 appeared relaxed and comfortable.On 05/21/26 at 10:14 AM, Administrative Nurse F stated Administrative Nuse D did the consents for medication.On 05/21/26 at 10:28 AM, Administrative Nurse D stated that they realized in March that they had not done the consents on any psychotropic medications. They began to do them at that time. Administrative Nurse D verified that the resident or representative did not consent to the medication. It must have been skipped over.The facility policy for Medication Management, Consents, and Monitoring, undated, documented prior to initiating psychotropic medications, the facility shall inform the resident and/or legal representative of medication name and purpose, risk and benefits, potential side effects, alternative treatment options, and the right to refuse treatment. The facility will maintain a signed consent in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 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. Based on observation, interview, and record review, the facility failed to accurately assess and monitor a psychotropic medication for Resident (R) 27, who received Ambien (a psychotropic medication used to induce sleep) nightly.Findings included:- R27's Electronic Medical Record (EMR) revealed the following diagnoses: insomnia (inability to sleep) and major depressive disorder (major mood disorder that causes persistent feelings of sadness).R27's 09/08/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R27 took an antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), and opioid (a class of controlled drugs used to treat pain). The MDS did not accurately document that R27 took a hypnotic (a class of medications used to induce sleep).R27's 09/08/25 Psychotropic Drug Use Care Area Assessment (CAA) documented R27 took pain medication which managed her pain well but lacked documentation of the hypnotic or diagnosis of insomnia.R27's Care Plan documented R27 took Ambien, which had a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). It directed staff to monitor pain, sleep patterns, and respirations. Do not give more than seven to ten days consecutively on 03/14/26.R27's Physician's Orders documented an order for zolpidem (Ambien) 5mg for insomnia every night, start dated 04/29/26.R27's EMR lacked evidence of monitoring for side effects and effectiveness for the ongoing use of the Ambien.On 05/19/26 10:06 AM, R27 reclined in her recliner with her feet up. R27 requested that the facility switch out her bed for the recliner. R27 stated all she does all day was just lay here. R27 reported that she liked staying in her room.On 05/21/26 8:59 AM Licensed Nurse (LN) G stated that how the staff monitored the effectiveness of a psychotropic medication is a reminder to document the behaviors and adverse reactions originating on the care plan and it goes to the orders, where the nurse saw it and documented on the medications in a nurse's note. Different medications have different frequencies for documentation. R5 had a reminder to document on the sertraline every six weeks. R27 did not have a reminder to monitor the zolpidem, and the nurses had not been monitoring this hypnotic medication for sleep.On 05/21/26 at 10:14 AM, Administrative Nurse F noted R27's Ambien should have been added to the care plan should have been documented on the care plan at admission so staff could document on the effectiveness of the medication.On 05/21/26 at 10:28 AM, Administrative Nurse D stated she fixed it so the zolpidem was now showing up on the care plan so the nurse would document it.The facility policy Medication Management, Consents, and Monitoring, undated, documented residents have the right to be free from unnecessary medications. The facility will ensure medications are used only when clinically indicated, monitored for effectiveness and adverse consequences, and supported by appropriate documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 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. Based on interview and record review, the facility failed to provide Resident (R) 2, and R54 a written notification of transfer to the resident and/or his representative as soon as practicable and failed to send a copy of that notification to the ombudsman. The facility also failed to provide R2 or the representative with the bed-hold upon discharge to the hospital.Findings included: 1. R2's Electronic Medical Record (EMR) revealed a diagnosis of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) and urinary tract infection (UTI-an infection in any part of the urinary system).R2's Minimum Data Set (MDS) tab documented a Discharge MDS on 11/20/25, 01/23/26, 03/14/26, and 04/26/26.R2's Nurse's Note, dated 11/21/25 at 01:50 AM, documented R2 returned to the facility after having the nephrostomy tubes changed, at 09:10 PM, R2 had a temperature of 102 Fahrenheit (F), and was sweating and had low back pain. The doctor was notified and advised staff that R2 likely required evaluation at the hospital due to similarities to previous UTI/sepsis episode. R2 was sent out to the hospital. R2's Nurse's Note, dated 01/23/26 at 05:10 PM, documented R2 had red colored urine and a fever. The doctor was notified and gave the order to send R2 to the emergency room for evaluation. R2's Nurse's Note, dated 03/14/26 at 04:56 PM, documented R2 had lower back pain and reported that one of her nephrostomy tubes felt like it was being pulled. Assessment of the right nephrostomy tube site revealed the nephrostomy dressing was soiled with what appeared to be dried mucus. The opening where the tube enters the skin also appeared larger than expected. Sutures were present and intact. A small amount of blood and sediment was observed in the right outermost tube and bag. The dressings were changed, and the doctor was notified and recommended applying mupirocin ointment to insertion site and monitoring closely.R2's Nurse's Note, dated 03/14/26 at 05:57 PM, documented R2 had a fever of 101.3 F and pain to her right outermost nephrostomy tube. The doctor was notified and provided an order to send R2 to the hospital.R2's Nurse's Note, dated 04/26/26 at 08:54 PM, documented R2 continued to have a temperature of 101.2 F an hour after she received Tylenol. The doctor was notified and gave the order to send R2 to the hospital if R2 worsened.R2's Nurse's Note, dated 04/26/26 at 09:55 PM, documented R2's temperature was now 102.9 and the nurse sent her to the hospital.R2's EMR lacked documentation that the bed hold was provided to the resident or the representative. The EMR also lacked documentation of a written notification to the residents and/or the representative, which explained the reason for the transfer to the hospital, or that the ombudsman was notified of the transfer. The facility was unable to provide the evidence upon request.2. R54's Nurse's Note, dated 03/26/26 at 01:39 PM, documented R54 had complaints of chest pain that radiated to his jaw and arms. The doctor was notified and gave the order to have him evaluated at the emergency room. R54 was transported by ambulance.R54's EMR lacked documentation of a written notification to the residents and/or the representative, which explained the reason for the transfer to the hospital, or that the ombudsman was notified of the transfer. The facility was unable to provide the evidence upon request.During an interview on 05/19/26 at 01:50 PM, Administrative Nurse E stated that, to her knowledge, the ombudsman was not notified of the discharges or transfers of the LTC residents.During an interview on 05/20/2026 11:30 AM, Social Service X stated she was unaware of the regulation to provide a bed hold to the resident or representative at the time of transfer. Social Service X was also unaware of the regulation to notify the residents and/or the representative in writing of the reason for the transfer and appeal policy and notify the ombudsman of transfers.During an interview on 05/20/26 at 08:54 AM, Administrative Staff A said the SS X had been responsible for providing bed holds and transfer/discharge notification. She also said that the ombudsman had not been notified in writing of transfers and discharges, but the facility contacted the ombudsman on 05/19/26 and have implemented a policy to contact the ombudsman in writing of all transfers and discharges.The facility's policy Ombudsman Notification and Transfer/Discharge Policy (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the facility shall comply with all applicable federal and Kansas requirements regarding resident transfer and discharge notification, including to the Kansas Long-Term Care Ombudsman Program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on observation, interview, and record review, the facility failed to accurately assess Resident (R) 5 and R27.Findings included:1. R5's Electronic Medical Record (EMR) revealed the following diagnoses: major depressive disorder (major mood disorder that causes persistent feelings of sadness).R5's 06/10/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R5 took a diuretic (a medication to promote the formation and excretion of urine), opioid (a class of controlled drugs used to treat pain), hypoglycemic (a type of medication to treat high blood glucose levels), and an anticonvulsant. The MDS did not accurately document that R5 took an antidepressant (a class of medications used to treat mood disorders).R5's 06/10/25 Falls Care Area Assessment (CAA) documented R5 received pain medications and diabetic medications.R5's 06/10/25 Psychotropic Drug Use CAA was not triggered due to not being accurately assessed on the MDS.R5's Care Plan documented R5 took an antidepressant for a diagnosis of major depressive disorder to improve functioning and reduce symptoms on 03/16/26.R5's June 2025 Electronic Medication Administration Record (EMAR) documented R5 took sertraline 50 milligrams (mg) on 06/04/25, 06/05/25, 06/06/25, 06/07/25, 06/08/25, 06/09/25, and 06/10/25.R5's Physician's Orders documented an order for sertraline 50 milligrams mg every evening, ordered on 05/29/25.R5's June 2025 Electronic Medication Administration Record (EMAR) documented R5 took sertraline 50 milligrams(mg) on 06/04/25, 06/05/25, 06/06/25, 06/07/25, 06/08/25, 06/09/25, and 06/10/25.On 05/21/26 at 08:26 AM, R5 sat in her recliner watching television. R5 appeared relaxed and comfortable.2. R27's Electronic Medical Record (EMR) revealed the following diagnoses: insomnia (inability to sleep) and major depressive disorder (major mood disorder that causes persistent feelings of sadness).R27's 09/08/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS recorded R27 took an antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), and opioid (a class of controlled drugs used to treat pain). The MDS did not accurately document that R27 took a hypnotic (a class of medications used to induce sleep).R27's 09/08/25 Psychotropic Drug Use Care Area Assessment (CAA) documented R27 took pain medication that managed her pain well but lacked documentation of the hypnotic or diagnosis of insomnia.R27's Care Plan documented R27 took Ambien, which had a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). It directed staff to monitor pain, sleep patterns, and respirations. Do not give more than seven to ten days consecutively on 03/14/26.R27's Care Plan was not updated with the Psychotropic Use care plan for the nurse to document behaviors and side effects. R27's Physician's Orders documented an order for zolpidem 10 mg every night, ordered on 09/02/25.R27's September 2025 Electronic Medication Administration Record (EMAR) documented R5 took zolpidem 10 mg on 09/02/25, 09/03/25, 09/04/25, 09/05/25, 09/06/25, 09/07/25, and 09/08/25On 05/19/26 at 10:06 AM, R27 reclined in her recliner with her feet up. R27 requested that the facility switch out her bed for the recliner. R27 stated all she does all day is lay here. R27 reported that she liked staying in her room.On 05/21/26 at 10:14 AM, Administrative Nurse F stated that, according to the EMAR, R5 had taken the antidepressant during the lookback period and should have been documented on the MDS. Administrative Nurse F verified understanding that since it was not documented on the MDS, it was not documented on the CAA, and on the care plan at admission. Administrative Nurse F verified that, according to the EMAR, R27 had taken the hypnotic medication during the lookback period and it should have been documented on the MDS.On 05/21/26 at 10:28 AM, Administrative Nurse D stated that she expected the MDS to accurately represent the residents.The facility policy for MDS Accuracy Policy, undated, documented the purpose of the policy was to ensure MDS assessments are completed accurately, in a timely manner, and in accordance with regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 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. Based on observation, interview, and record review the facility failed to identify and implement resident-centered interventions and monitor effectiveness of interventions to prevent falls for Resident (R) 3 who was at high risk for falls. Findings included:- R3's Electronic Health Record (EHR) documented diagnoses of pneumonitis (an infection in the lungs due to inhalation of food and vomit), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), polyosteoarthritis (degenerative changes to many joints characterized by swelling and pain), encephalopathy (a broad term for any brain disease that alters brain function or structure), dementia (a progressive mental disorder characterized by failing memory and confusion), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), urinary tract infection (UTI-an infection in any part of the urinary system), overactive bladder (a sudden, uncontrollable urge to urinate that is difficult to postpone), and diarrhea.R3's Annual Minimum Data Set (MDS), dated 03/19/2026, documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. R3 required a wheelchair for mobility. The MDS documented that R3 was set up for clean-up assistance for eating and was dependent on transfers and substantial to maximal assistance for most of her other activities of daily living (ADL).R3's Care Plan, dated 03/17/25 documented she was at risk for falls due to weakness, impaired balance, incontinence and disease conditions. The care plan directed staff to place the bed in the lowest position as a fall intervention for a fall on 05/03/25. R3's Care Plan, directed staff to ensure bedside commode is in the bathroom with the curtain pulled as a 05/18/26 fall intervention.R3's Care Plan, documented frequent visual checks between 09:00 PM and 12:00 AM for the fall date of 12/15/25.R3's re-admission Fall Risk Evaluation, dated 02/20/26, documented that she had a history of one or more falls within the previous 6 months and documented she is not a low fall risk.R3's Annual Fall Risk Evaluation, dated 03/14/26, documented a history of one or more falls within the previous 6 months and documented she is not a low fall risk.R3's Safety Event-Copy of Fall Assessment and Root Cause Analysis, dated 05/18/26, documented an unwitnessed fall with injury, and that R3 was reaching for something and slid or fell from her wheelchair. R3's EHR Progress Note, dated 03/07/26 and timed at 03:38 PM, documented by a note by Licensed Nurse (LN) H, which listed the root cause of the fall was R3 attempted to transfer to the commode and did not use her call light. LN H further documented that Certified Nursing Aide (CNA) N had discovered R3 sitting on the floor in front of her wheelchair with one hand on the grab bar right outside of her bathroom and that R3 stated she was trying to use the commode. LN H documented that R3 did not use her call light and that neurological assessments were initiated because R3 had a BIMs score of five that indicated severe cognitive impairment.Observed on 05/13/26 at 02:36 PM, R27 sat in her wheelchair in the common area television room and played dominoes with staff and another resident.Observed on 05/20/26 at 08:05 AM, R3 lay in bed with her eyes closed on a scoop mattress. The bed was raised approximately three to four feet from the floor and was not in the lowest position.Observed on 05/21/26 at 08:22 AM, R3 lay in bed. Her bed was in a low position, approximately six inches from the floor, with a fall mat at the bedside.On 05/20/26 at 03:08 PM, Administrative Nurse D said that she could not define or explain what frequent checks were because there was no way to quantify that time frame. Administrative Nurse D stated it was a task and was not something staff can put an exact time frame on.On 05/21/26 at 09:45 AM, CNA N said staff would leave the door to the bathroom propped open with a trash can. CNA N said they pull the privacy curtain if R3 is not using the bedside commode. CNA N said R3 is to have her bed in the lowest position with a fall mat next to her bed and said these are the only fall interventions she is aware of.On 05/21/26 at 11:45 AM, CNA M said that R3's Care Plan documents that her bed is to be in the lowest position with a fall mat on the floor next to the bed. CNA M said that the plan documented the bedside commode was to be kept in the bathroom blocking (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the doorway. CNA M further stated that there was nothing in the bathroom that R3 was required to use and the door to the bathroom was propped open with a trash can per R3's request.The facility fall prevention protocol policy is undated and documents that each elder residing at this facility will be provided care that ensures the elder's environment remains as free from accident hazards as possible. The protocol further documents that an elder is considered to need high fall risk prevention protocols if the elder has had a fall while living at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor	304 W 7th St Wellsville, KS 66092

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 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. Based on interview and record review, the facility failed to ensure that Resident (R) 2 received appropriate treatment and services to prevent urinary tract infections to the extent possible by failing to keep the urine collection bag attached to the nephrostomy(an artificial opening created between the kidney and the skin which allows for the urinary diversion) tubes below the level of the kidney.Findings included:- R2's Electronic Medical Record (EMR) revealed a diagnosis of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) urinary tract infection (UTI-an infection in any part of the urinary system), and a kidney infection.R2's 07/06/25 admission Minimum Data Set (MDS) documented R2 had an indwelling catheter and took antibiotics.R2's 07/06/25 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented R2 was in isolation for a UTI and had nephrostomy tubes in both kidneys, which staff are managing.R2's EMR contained Discharge Instructions for Nephrostomy Tube Care, dated 05/15/26, which documented the nephrostomy tube drains urine from the kidney around the blockage to a bag outside the body. It instructed that the bag should always remain below the bladder. It should never be higher than the bladder.On 05/20/26 at 2:42 PM, R2 sat in the recliner in a reclined position. R2 had an apron with pockets on the chest for her urostomy bags. The bags were positioned in the pockets on her chest as she relaxed and watched television.On 05/20/26 at 2:58 PM, Certified Nurse Aide (CNA) P stated the staff transferred R2 with a Hoyer lift (total body mechanical lift). R2 was dependent on staff for all transfers. CNA P stated the staff knows R2 had nephrostomy tubes, and they were careful not to pull or tug on them. They always had the nurse present when they provided cares for R2. R2 had bags on the side of her bed to place the urine collection bags in while she was in bed.On 05/20/26 at 3:02 PM, Licensed Nurse (LN) G Stated the urine collection bags were to be in the bags on the sides of the recliner. They were never to be above the level of R2's bladder. LN G went in at that time and moved the bags.During an interview on 05/21/26 at 10:28 AM, Administrative Nurse D stated it was her expectation that staff always keep the urine collection bags below the level of the bladder to prevent back flow and infection.The facility's policy Catheter and Nephrostomy Tube Care Policy documented drainage bags are to remain below the level of the bladder or kidney insertion site.