

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Rolling Hills Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1319 Seville Street Wichita, KS 67209	
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 and interviews, the facility failed to follow sanitary dietary standards related to food storage, unclean floors, and monitoring of dishwasher temps. Findings included:- During the initial tour on 06/22/2026 at 07:42 AM, observation revealed the following:The floors were sticky and dirty, thick dark dirt was around all standing work area legs. There was a cup of pudding with whipped topping in the single refrigerator that was undated and unlabeled. There were seven small bags of chicken in a steam table pan that were unlabeled and undated in the two-door refrigerator.The dishwasher was missing temperature recordings for 06/19/2026, 06/20/2026, 06/21/2026, and 06/22/2026.On 06/22/2026 at 08:00 AM, Dietary Staff BB stated the floors needed deep cleaning. He stated the kitchen floors were deep cleaned twice a year. Dietary Staff BB stated staff mopped the floor every night. He said the chicken was brought in by a family member, and the bags should have been dated before they were placed in the refrigerator. Dietary Staff BB stated he would dispose of the pudding that was undated and unlabeled. He stated the dishwashing temperatures were to be taken daily by the dishwasher and he would fill out the temperature log for 06/22/2206, and label the food brought in for 06/22/2026.The facility's Food Brought by Family or Visitors policy dated 10/2025 documented liberalized diets would be permitted as much as possible. Staff must be aware of and approved. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers would be labeled with the resident's name, the item and the use by date.The facility's Food Safety Requirements policy dated 10/2025 documented foods should be received and stored in a manner that complies with safe food handling practices. The community would procure food from approved sources or those considered satisfactory by federal, state, and local authorities.		

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on observation, record review, and interview, the facility failed to offer and provide or obtain informed declination for the influenza and pneumococcal vaccination for Resident (R) 1, R5, R49, and R62 or their representative. Findings included:- The Electronic Medical Record (EMR) for R1, R5, R49, and R62, lacked evidence of an informed declination for the influenza and pneumococcal vaccinations. The Immunizations tab for the above residents noted that the vaccinations had been offered but refused by the residents. Upon request, the facility was unable to provide documentation that the vaccination information, including risks verses benefits was provided to R1, R5, R49, and R62 and was unable to provide documentation of informed declination. On 06/24/2026 at 10:25, Licensed Nurse (LN) G, the facility Infection Preventionist, stated that each fall the influenza and pneumococcal vaccination was offered to residents. If the resident chose to get the vaccination, it was given. LN G stated the facility did not have residents or their representative sign a consent to decline the vaccination, but she did keep a log of who received or refused the vaccinations each year. On 06/24/2026 at 11:54 AM, Administrative Nurse D stated that a consent should be signed by the resident or their representative when the vaccinations were declined so there was a record of the declination. Administrative Nurse D stated she would make sure that consents were provided to residents moving forward when vaccinations were being offered. The facility's Vaccination of Residents, Including Influenza, Pneumococcal, RSV, and COVID-19, Reporting of dated September 2025 documented residents would be offered vaccinations per CDC and CMS guidelines. 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. The resident or the resident's legal representative may refuse vaccinations for any reason. Residents have the right to refuse, be free of interference, coercion, discrimination, and reprisal for the community staff for refusing to take any vaccines. If vaccinations are refused, the refusal shall be documented in the resident's medical record.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on observation, record review, and interview, the facility failed to obtain an informed declination for the COVID-19 vaccination was provided for Resident (R)1, R5, R49, and R62 or their representative. Findings included:- Review of Electronic Medical Record (EMR) for R1 lacked evidence of informed declination for the COVID-19 vaccination. The Immunizations tab for R1 noted that the vaccinations had been offered June 2026 but refused by the resident.R5's EMR lacked evidence of informed declination for the COVID-19 vaccination. The Immunizations tab for R5 noted that the vaccinations had been offered June 2026 but refused by the resident.R49's EMR lacked evidence of informed declination for the COVID-19 vaccination. The Immunizations tab for R49 noted that the vaccinations had been offered June 2026 but refused by the resident.R62's EMR lacked evidence of informed declination for the COVID-19 vaccination. The Immunizations tab for R62 noted that the vaccinations had been offered June 2026 but refused by the resident.On 06/24/2026 at 10:25 AM, Licensed Nurse (LN) G, the facility Infection Preventionist, stated that COVID vaccinations were offered to residents. If the resident chose to get the vaccination, it was given. LN G stated the facility did not have residents or their representative sign any consent or informed declination if they declined the vaccination, but she did keep a log of who received or refused the vaccinations each year.On 06/24/2026 at 11:54 AM, Administrative Nurse D stated that a consent/declination should be signed by the resident or their representative when the vaccinations were declined so there was a record of the declination. Administrative Nurse D stated she would make sure that consents were provided to residents moving forward when vaccinations were being offered.The facility's Vaccination of Residents, Including Influenza, Pneumococcal, RSV, and COVID-19, Reporting of dated September 2025 documented residents would be offered vaccinations per CDC and CMS guidelines. 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. The resident or the resident's legal representative may refuse vaccinations for any reason. Residents have the right to refuse, be free of interference, coercion, discrimination, and reprisal for the community staff for refusing to take any vaccines. If vaccinations are refused, the refusal shall be documented in the resident's medical record.		

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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. Based on interviews and record review, the facility failed to provide the correct Center for Medicare and Medicaid (CMS) Form 10055, Advanced Beneficiary Notice (ABN), for two residents, Resident (R)34 and R55. Findings included:- The Medicare ABN form informed the beneficiaries Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included options for the beneficiary to () receive specified services listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for payment, but I can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment of services. (3) I do not want the listed services.The facility's Medicare ABN form staff provided to R34 (or their representative) was form CMS-R-131 for the last covered day of 02/10/2026.The facility's Medicare ABN form staff provided to R55 (or their representative) was form CMS-R-131 for the last covered day of 06/02/2026.On 06/23/2026 at 01:30 PM, Social Service X stated the form provided was what she had been told to use and did not realize that it was incorrect.On 06/24/2026 at 11:54 AM, Administrative Nurse D stated they would make sure to get the right form to use moving forward,The facility's Beneficiary Notices policy, dated July 2025, documented that a Medicare beneficiary had the right to have Medicare decide to determine if skilled services would be covered by Medicare. The Skilled Nursing Facility Advance Beneficiary Notice of non-coverage (SNF ABN) CMS 10055 informed the residents of potential non-coverage and that the residents would understand they are accepting financial liability if it was determined that the services may not be covered by Medicare.		

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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. Based on observation, record review, and interviews, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R) 62. Findings included:- R62's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety, major depressive disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), and need for assistance with personal care. R62's admission Minimum Data Set (MDS) dated 05/07/2026 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R62 received antipsychotic medication and an antidepressant medication during the observation period. R62's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/07/2026 documented R62 triggered due to taking antipsychotic medications and antidepressants due to dementia, behaviors, and depression. The CAA documented R62 was recently re-admitted to the facility from a behavioral hospital. R62's Care Plan documented the following:10/20/2025-R62 had a mood problem displayed agitation, anxiety, or restlessness related to cognitive impairment and dementia, and childlike mentality. R62 had the potential and demonstrated behaviors of rejection care and constant ambulation. Staff were to assess and evaluate R62's behavior and cognition systematically and continually throughout the day and evening.05/14/2026-R62's Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) plan listed Risperdal (antipsychotic medication) increased mortality in elderly patients with dementia-related psychosis in elderly patients with dementia-related psychosis treated with antipsychotic drugs were at an increased risk of death. Risperidone was not approved for the treatment of patients with dementia-related psychosis. Encourage as much participation in activities that the resident can endure or comprehend. Give clear explanations of all care to be provided. R62's EMR under the Orders tab revealed the following physician order:Risperdal oral tablet 0.5 milligrams (mg) (risperidone). Give 1.5 mg by mouth two times a day for behaviors dated 05/04/2026. Review of R62's clinical record lacked physician documentation of risk versus benefit of administration of antipsychotic medication with a non-approved indication of use for R62 who had a diagnosis of dementia. The facility provided the physician documentation dated 06/24/26. On 06/24/2026 at 09:43 AM, Administrative Nurse E stated nurses or department heads would be the person to talk to the physician for the correct indication of medication use. Administrative Nurse E stated it was the department head's responsibility to ensure the residents had a risk versus benefit. On 06/24/2026 at 11:56 AM, Administrative Nurse D stated the nurse practitioner for the facility writes orders for psychotropic medications for the residents in the facility. Administrative Nurse D stated the nurse practitioner does understand what an approved indication for psychotropic drug use was. She stated department heads go over what was an approved indication for psychotropic drugs with staff at each standup meeting. Administrative Nurse D stated it was the floor nurses and department heads responsibility to ensure the risk vs benefit for psychotropic medication was understood by the family's and residents and signed by the physician. The facility's Use of Psychotropic Drugs dated 05/25 documented residents would only receive psychotropic or other approved indications that influence brain activity when necessary to treat specific conditions for which that were indicated and effective and would not be used for discipline or convenience of the staff.		

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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** Based on observation, record review, and interview, the facility failed to provide Resident (R) 5, or their representative with a copy of the bed hold policy, written notification of transfer, and failed to notify the ombudsman when she was transferred to the hospital. The facility failed to ensure the Notice of Transfer to Hospital form included the required rights to appeal and the ombudsman information. Findings included:1. R5's Electronic Medical Record (EMR) recorded a Discharge Minimum Data Set (MDS) for an unplanned discharge to an acute hospital with a return anticipated on 04/30/2026.R5's Entry MDS dated 05/06/2026 recorded a reentry to the facility from an acute setting.R5's EMR lacked documentation the facility provided the bed hold, notice of transfer, and notification to the ombudsman for R5's transfer to the hospital on [DATE]. Upon request, the facility was unable to provide.R5's Entry MDS dated 05/06/26 recorded a reentry to the facility from an acute setting.2.R9's EMR recorded a Discharge MDS for an unplanned discharge on [DATE] to an acute hospital with a return anticipated.The facility provided a bed hold, notice of transfer and notice to the ombudsman of the transfer for R9's 03/06/2026 hospitalization. R9's Notice of Transfer to Hospital form dated 03/06/2026 documented when, where, and why he was transferred to the hospital. R9's responsible party was notified by phone of the transfer, and the form was not provided to the representative. The transfer form lacked information about the right to appeal and contact information. The transfer form lacked ombudsman information and contact information.On 06/23/2026 at 10:56 AM, Social Services X stated that she got verbal approval for the bed holds and notice of transfers. Social Services X stated that the transfer notice was sent with the resident to the hospital but was not sent to their representative. Social Services X stated she sent the ombudsman the transfers at the end of each month. Social Services X stated for R7 she did not complete a bed hold form, notice of transfer form, or notify the ombudsman of her transfer to the hospital since the resident's family requested that she be sent to the hospital and verbally agreed to the bed hold. Social Services X had not been aware that the notice of transfer form needed to include the right to appeal information or the ombudsman information.On 06/23/26 at 10:45 AM, Administrative Staff A stated that Social Services X completed the bed hold, notice of transfer, and notified the ombudsman of all discharges. She stated the bed hold should be completed on all transfers to the hospital and the notice would be updated to include all needed information. The facilities Bed Hold policy dated May 2026 documented upon admission and when a resident is transferred for a non-emergency hospitalization or for therapeutic leave, a representative of the business office would provide information concerning our bed-hold policy. When emergency transfers are necessary, the facility will provide the resident and the resident representative with information concerning our bed-hold policy per state law as applicable. The bed-hold information will include any charges that the resident may incur as well as the time limit established by the State Medicaid Plan for which the facility will reserve the resident's bed space.A policy for notification of transfer and notification to the ombudsman was requested by the facility on 06/24/26 but was not received.		

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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** Based on observation, interview, and record review, the facility failed to implement effective person-centered interventions to prevent falls for two residents. Resident (R)38, who had three falls with staff, and R1, whose fall interventions were not implemented. Findings included:- R38's Electronic Health Record (EHR) revealed diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), reduced mobility, muscle weakness, and absence of the right upper limb.The Annual Minimum Data Set (MDS), dated [DATE], documented R38 had intact cognition. R38 required substantial staff assistance for oral hygiene, personal hygiene, mobility, transfers, and upper body dressing. R38 had upper body functional impairment on one side, lower body functional impairment, had no falls, and did not ambulate.The Quarterly MDS, dated 05/29/2026, documented R38 had intact cognition. R38 was dependent on staff for transfers, toileting, hygiene, and substantial assistance with mobility, upper-body dressing, and personal hygiene. R38 had upper body functional impairment on one side, lower body functional impairment, had one or more non-injury falls, and did not ambulate.The Fall Risk Assessment, dated 01/01/2026, documented R38 was a high risk for falls.The Fall Risk Assessment, dated 04/01/2026, documented R38 was a low risk for falls.R38's 06/02/2026 Care Plan had the following fall interventions:11/22/2023 Staff were to answer his call light promptly, update the care plan as needed, encourage exercise and mobility to maximize and maintain strength, balance, and coordination, and make sure appropriate shoes or non-slip socks are on when not in bed or during any transfers.08/07/2024- Staff was educated to clip the call light onto the bed instead of a bedside table for easier access.04/02/2025- Hoyer lift (total body mechanical lift) for transfer and therapy to evaluate.03/10/2026- Staff is not to place the slide board underneath him until fully ready to transfer.03/18/2026- Therapy referral and provide education to R38 on not to self-transfer.04/04/2026- Place a printed reminder to use the call light and wait for assistance.The Fall Investigation, dated 03/10/2026 at 09:00 PM, documented Certified Nurse Aide (CNA) O assisted R38 with a transfer from the wheelchair to his bed using a slide board. CNA O stated he briefly turned around to put on gloves, and during that time, R38 attempted to self-transfer to the bed and fell onto the floor. R38 was assisted up off the floor by two Certified Medication Aides (CMA) and one Licensed Nurse (LN). R38 did not sustain any injuries.The Fall Investigation, dated 03/19/2026 at 10:15 PM, documented CNA P was assisting R38 to bed. She had placed a slide board on the bed and his wheelchair. She had taken off the armrest of the wheelchair and was going to get assistance to help with the transfer when R38 attempted to self-transfer. R38 got stuck between the bed and the wheelchair, so CNA P had to lower him to the floor. R38 was assisted off the floor by three staff. CNA P was reminded never to take off the armrest from the wheelchair before there was another staff member in the room to help with the transfer. R38 sustained an abrasion (scrape) on his left elbow. The Fall Investigation, dated 04/04/2026 at 08:30 PM, documented CNA Q reported R38 attempted to transfer himself to the bed without assistance. She had to lower R38 to the floor to avoid injury. R38 was assisted off the floor by four staff. CNA Q was reminded not to wheel R38 so close to the edge of the bed without getting another staff member for assistance, as R38 had decreased safety awareness. R38 did not sustain any injury. On 06/23/2026 at 09:40 AM, CNA M and CNA N placed the Hoyer lift sling under R38 and attached the straps to the lift. CNA N used the lift remote to raise R38, CNA M positioned him over his wheelchair, and CNA N lowered him into his wheelchair. CNA M stated that R38 had not had any falls, and staff used the Hoyer lift when R38 felt weak. CNA M stated he (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unsure of any fall interventions in place for R38. CNA N stated he was new to the facility and was unaware of what R38's fall prevention interventions were. On 06/24/2026 at 10:00 AM, LN H stated staff had been using the Hoyer lift for transfers as part of his fall prevention. R38 had anti-slip socks, and they had encouraged R38 to call for assistance before he tried to get up. There should always be two staff members in the room for transfers. On 06/24/2026 at 11:54 AM, Administrative Nurse D stated that the facility used a communication board for staff to look at to see if there were any changes to the residents' care plan interventions or conditions. The department heads were supposed to make sure that staff was aware of any changes, and staff could look at the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). Administrative Nurse D stated R38 used a Hoyer lift as a safety precaution due to his size and to help staff with his transfers. The facility's Falls and Fall Risk, Managing policy, dated June 2026, documented staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The interdisciplinary team would attempt to identify appropriate interventions to reduce the risk of falls. If a systemic evaluation of the resident's fall risk identified several possible interventions, the staff may choose to prioritize interventions. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.- R1's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hypertension (HTN-elevated blood pressure), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following 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) affecting left nondominant side, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS document R1 had an impairment of one side of his upper body. The MDS documented that R1 needed supervision or touching assistance for eating and substantial/maximal assistance with bathing and was dependent on staff for toileting. The MDS documented R1 had no falls since admission or prior admission during the observation period. The Fall Care Area assessment dated [DATE] documented R1 triggered for falls due to sustaining falls and high-risk medication, such as antidepressant (a class of medications used to treat mood disorders) due to depression; R1 had a history of cerebral infarction, generalized muscle weakness, and needed assistance with personal care. R1's Care Plan documented the following fall interventions: 04/25/2025- R1 was to have a long brake extender with colored tape on the left side of his wheelchair. 05/14/2025 -Maintenance was to tighten R1's brakes. 05/17/2025-R1 to have a Dycem (non-slip mat used for stabilization and gripping to prevent slipping) in the wheelchair, above and below the cushion. 05/27/2025-R1 was expected to have falls related to noncompliance and cognition deficit post CVA, reduced mobility, and a need for assistance with personal care. 08/07/2025-R1 was to have anti-rollbacks placed on his wheelchair to prevent falls. 01/14/2026-Education provided to R1 to not self-transfer, and to use the call light. On 06/22/2026 at 10:12 AM, staff transferred R1 from his wheelchair to his bed by staff. R1 did not have a Dycem under his wheelchair cushion, and R1 did not have a Dycem on top of his wheelchair cushion. R1 did not have a brake extender with colored tape on his wheelchair. On 06/23/2026 at 02:00 PM, staff laid R1 in his bed. R1 did not have a Dycem under his wheelchair cushion, and R1 did not have a Dycem on top of his wheelchair cushion. R1 did not have a brake extender with colored tape on his wheelchair. On 06/22/2026 at 10:10 AM, Certified Medication Aide (CMA) R stated she was informed of the interventions for each resident in a standup meeting, before her shift. She stated she does have (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to collaborate care and services provided by the facility with the care and services provided by hospice for Resident (R)11. Findings included:- R11's Electronic Health Record (EMR) documented diagnoses of senile degeneration of the brain (the progressive deterioration of brain cells and their connections, leading to cognitive decline and behavioral changes in older adults), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), pain, and adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R11 had severely impaired cognition. R11 was dependent upon staff for all activities of daily living (ADLs). The MDS documented R11 received hospice services. R11's 06/22/2026 Care Plan included the following interventions for R11: 09/15/2025- administer medications for comfort before an activity, expect weight loss or gain due to terminal diagnosis, assist with supporting ADL functions, follow practitioner and Hospice orders for symptom control, keep R11 comfortable to the extent possible. The care plan lacked instruction on the services provided by hospice, including the frequency and type of support visits, supplies and medical equipment provided by hospice, and medications covered by hospice. Review of R11's clinical record revealed R11 was admitted to hospice care on 05/17/2025 with the diagnosis of senile degeneration of the brain. On 06/23/2026 at 10:30 AM, R11 laid in bed with her eyes closed. On 06/23/2026 at 01:00 PM, Administrative Nurse E verified that the visits, supplies, and medication provided by hospice were not documented in the resident's care plan. She stated she had just done an audit on all the care plans for residents on hospice and must have missed hers. The facility's Hospice Program policy, dated December 2025, documented the community may contract hospice services for residents who wish to participate in such programs, including services that will be provided and the coordination of services. The community may limit the hospice providers in terms of the coordination and communication of care within the community. The facility identifies a member of the IDT who is responsible for or working with the hospice representative. This person's responsibility provides collaboration and coordination of hospice care, communication with hospice representatives, and other health care providers participating in the hospice care. The community retained the ultimate responsibility for the care plan. Coordination of the care plan with the hospice provider, community staff, and residents' families. The care plan may be in two portions, each maintaining its own, but changes must be discussed. To promote continuity of care, collaborate with the hospice, nursing home and resident representative on the coordinated care plan noted in the medical record to include, but not limited to measurable goals and interventions based upon comprehensive and ongoing assessments. Interventions that address pertinent non-pharmacological and pharmacological interventions to manage pain and other symptoms of discomfort.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to implement adequate infection control practices related to sanitary storage of respiratory supplies and hand hygiene during wound care for Resident (R) 4. Findings included:- On 06/22/2026 at 07:55 AM, during the facility walk through, R20's nasal cannula laid on his bed, R20's nasal cannula (a lightweight, flexible device that delivers supplemental oxygen directly into your nose) was not stored in a sanitary container. R20's nebulizer mask (a device that changes liquid medication into a mist easily inhaled into the lungs) laid uncovered on her bedside table, R20's nebulizer was not stored in a sanitary container. R68's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask laid on the bottom of her bed, R68's feet laid on the CPAP mask. R68's CPAP mask was not stored in a sanitary container. On 06/23/2026 at 08:55 AM, Consultant GG and her assistant entered R4's room and put on a gown. Licensed Nurse (LN) G was already in the room and had prepared the top of a table with a barrier and the wound care supplies on top of the barrier. LN G performed hand hygiene with hand sanitizer from a dispenser on the wall in the room. Consultant GG applied clean gloves, and her assistant applied sanitizer to her hands and then applied clean gloves. R4 was positioned on his left side by LN G and the assistant. LN G removed her gloves, did hand hygiene, and applied clean gloves. Consultant GG was handed clean gauze that had wound cleaner on it by LN G. Consultant GG wiped R4's right leg wound with the moistened gauze pad and discarded into the trash. Consultant GG removed her dirty gloves and discarded them in the trash. Consultant GG applied clean gloves, and LN G handed her pieces of calcium alginate (a highly absorbent, non-adherent wound dressing) to wound bed, then applied the new dressing to the wound, she then removed her gloves and discarded them in the trash. Consultant GG's assistant and LN G repositioned R4 onto his left side and removed their gloves and performed hand hygiene before applying clean gloves. Consultant GG applied clean gloves (no hand hygiene performed prior). LN G handed Consultant GG a clean gauze pad that had wound cleanser gloves to begin clean wound to his left posterior leg and discarded the gauze in the trash. Without changing gloves, Consultant GG placed pieces of calcium alginate in the wound bed and then applied a new dressing. LN G handed Consultant GG another clean gauze pad and sprayed the gauze with wound cleanser. Consultant GG wiped the wound on R4's coccyx (area at the base of the spine) with the gauze pad and discarded the gauze in the trash and removed her gloves and discarded them on the trash. Consultant GG and her assistant sanitized their hands after removing their gown and gloves. Consultant GG and her assistant gathered their supplies and exited R4's room. LN G removed her gloves and sanitized them before applying clean gloves. LN G continued wound care and applied the wound vac to the coccyx wound using appropriate gloving and hand hygiene as needed. On 06/23/2026 at 09:00 AM, Consultant GG stated yes, she should have changed her gloves and sanitized her hands after she had cleaned R4's leg wound and then applied clean gloves. Consultant GG stated she also should have taken off her gloves after she applied the new dressing to the wound and began the cleaning of his wound to his coccyx. On 06/24/2026 at 10:25 AM, LN G stated she expected any staff or consultant that was performing any cares would perform hand washing/hygiene before beginning a care, then after removing gloves, then apply clean gloves to prevent infection. LN G stated that was just standard practice. LN G stated oxygen tubing, CPAP masks and nebulizer masks should be stored in a clean storage bag when not in use. On 06/24/2026 at 12:54 PM, Administrative Nurse D stated that hand hygiene was expected to be done by anyone prior to any care being done as well as after removing dirty gloves or applying clean gloves as well after the task was completed. Administrative (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse D stated that every Sunday night new oxygen tubing and bags for storage of the tubing were provided to residents. Residents should also have bags for the nebulizer and CPAP mask to be stored in when not in use. The facility's Administering Medications through a Small Volume Nebulizer policy dated November 2025 documented the disassembled parts should be rinsed with hot water after each use. Once daily wash the disassembled parts with warm, soapy water, then rinsed thoroughly. For a deeper clean and disinfection, soak the parts in a solution of one-part white vinegar to three parts water for 30 minutes to an hour, followed by a final rinse, allow to air dry on a lint free towel. When the equipment was completely dry, store it in a plastic bag with the resident's name and the date on it. The facility's CPAP/BiPAP Support policy dated March 2026 lacked guidance on proper storage of the mask when not in use. The facility's Wound Care Guidelines policy dated June 2025 documented Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. Wipe nozzles, foil packets, bottle tops, etc., with alcohol before opening, as necessary. {Note: This may be performed at the treatment cart.} 1. Close the door and pull the privacy curtain. 2. Establish clean field on resident's overbed table (dry paper towel is adequate). 3. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 4. Wash and dry your hands thoroughly. 5. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 6. Apply disposable gloves. Loosen tape and remove dressing. 7. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 8. Put on disposable gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids are likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 9. Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. 10. Pour liquid solutions directly on gauze sponges on their papers. 11. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 12. Wear disposable gloves when physically touching the wound or holding a moist surface over the wound. 13. Place one (1) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. 14. Remove dry gauze. Apply treatments as indicated. 15. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, date and apply to dressing. 16. Be certain all clean items are on clean field. 17. Remove the disposable cloth next to the resident and discard into the designated container. 18. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard them into designated container. Wash and dry your hands thoroughly.		

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to submit complete and accurate staffing information through the Payroll Based Journal (PBJ) as required. Finding included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2025, Quarter 3 and 4, and FY 2026, Quarter 1 and 2, indicated the facility had excessively low weekend staff. Review of the facility staffing schedule revealed adequate weekend staffing for the quarters above. On 06/24/2026 at 09:45 AM, Administrative Staff B stated she compared the timesheets and the payroll forms and submitted them to the corporate office. The payroll specialist at the corporate office looked it over, and then it was submitted to CMS. Administrative Staff B further stated that she did not understand why it showed low weekend staff, as there are the same number of staff on the weekend as there were during the week. On 06/24/2026 at 01:30 PM, Administrative Staff A stated that they discovered administrative staff had accidentally been reported as hands-on staff during the week, and then on the weekend, they were not counted. She said it was fixed and would be submitted correctly. The facility's Payroll-Based Journal policy, dated October 2025, documented the community would submit payroll data in a uniform format to CMS, including staffing information for community, agency, and contract staff. The information was submitted electronically based upon specifications determined by CMS, which included the category of work for each person on direct care staff, resident census data, and information on direct care staff turnover and tenure, on the hours of care provided by each category of staff per resident per day, and hours worked.		