

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Osage Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 Main Street Osage City, KS 66523	
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 - Some	Provide and implement an infection prevention and control program. Based on record review, observations, and interviews, the facility failed to implement adequate infection control practices when staff failed to store Resident (R)25'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) in a sanitary manner when not in use. The facility failed to ensure proper infection control standards were followed related to hand hygiene during catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care for R32. Findings included:- On 07/06/2026 at 09:25 AM, R25's CPAP laid directly on the bedside table and was not in a container. On 07/07/2026 at 07:43 AM, R25's CPAP laid directly on the table next to her recliner and was not in a container. On 07/07/2026 at 10:30 AM, Licensed Nurse (LN) I donned personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) to perform catheter care for R32. LN I touched her hair, pushed R32's wheelchair from the bathroom to his bed, and she then closed the window blinds. LN I did not change her gloves or perform hand hygiene. LN I then cleaned R32's suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) with normal saline. LN I then doffed the glove from her right hand and donned a new glove without performing hand hygiene. On 07/07/2026 at 02:46 PM, R25's CPAP continued to lay directly on the table next to her recliner, not in a container. On 07/08/2026 at 09:10 AM, R25's CPAP laid directly on the table next to her recliner, not in a container. On 07/07/2026 at 10:48 AM, LN I stated the process for performing catheter care was to change the gloves between the soiled and clean parts of the care and washing hands between glove changes. On 07/08/2026 at 10:55 AM, Certified Nurse Aide (CNA) N stated the process for storing a CPAP mask between uses was to place it in a bag and keep it closed. On 07/08/2026 at 11:02 AM, LN H stated the process for the sanitary storage of R25's CPAP was that the mask should be taken apart, cleaned, dried then placed in the bag. On 07/08/2026 at 12:36 PM, Administrative Nurse D stated she expected hand hygiene to be performed between glove changes. She also stated that R25's CPAP's manufacturer did not recommend the mask to be stored in a bag. Administrative Nurse D stated R25 did not like to have the CPAP mask in a bag because she had difficulty getting it out of the bag. The facility was unable to provide a policy related respiratory equipment storage when not in use when requested on 07/08/2026. The facility's Hand Hygiene, dated 01/20/2026, documented all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applied to all staff working in all locations within the 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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, record review, and interviews, the facility failed to ensure pressure-reducing measures were implemented for Resident (R)12 when staff failed to float her heels per her orders and plan of care. Findings included:- R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN-elevated blood pressure), chronic pain, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Modification of Significant Change Minimum Data Set (MDS) for R12, dated 05/12/2026, recorded a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R12 was dependent on staff for toileting and bathing. The MDS documented R12 was at risk for developing pressure ulcer/injury. The MDS documented R12 had one unhealed pressure ulcer/injury. The MDS documented R12 had one Stage 1 (pressure wound which appears reddened, does not blanch, and may be painful but is not open) during the observation period. R12's Pressure Ulcer/Injury Care Area Assessment (CAA), dated 05/12/2026, documented R12 was frequently incontinent of bowel and bladder, was at risk for skin breakdown, and had an existing pressure ulcer. The CAA documented R12 needed increased frequent skin monitoring, repositioning, hygiene care, and pressure relieving interventions to prevent further skin impairment. R12's Care Plan documented: 05/18/2026 - R12 had potential for impairment for skin integrity of the peri area related to incontinence. Staff float R12's heels while in bed. Staff offer R12 Geri-sleeves (are soft, breathable, non-compression fabric tubes designed as a protective barrier) in the mornings. Nursing to perform weekly skin assessments. R12's EMR under Orders documented the following physicians' orders: Bilateral heels, gently cleanse with normal saline and pat dry; apply Skin-prep (liquid skin barrier) and allow to dry well every shift for skin tissue health, dated 02/19/2026. Float heels while in bed; every shift for skin protection, dated 04/14/2026. R12's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 10/08/2025 documented a score of 17 indicating at risk. On 07/08/2026 at 07:55 AM, R12 lay on her bed on her back with her eyes closed. R12's head was elevated, and her heels lay directly on her mattress; R12's heels were not floated. On 07/08/2026 at 07:42 AM, R12 lay on her bed on her back with her eyes closed. R12's heels lay directly on her mattress; R12's heels were not floated. On 07/08/2026 at 10:39 AM, Certified Nurse's Aide (CNA) M stated if a resident had a wound or needed their boots, the boots would be in the room. She stated a nurse would let her know if a resident should have their heels floated. CNA M stated the nurse does go behind the CNAs to ensure the residents have what they need in place. CNA M stated she did have access to the care plans, and if she was unsure what a resident needed, she would look at the care plan. On 07/08/2026 at 10:47 AM, Licensed Nurse (LN) G stated all nursing staff were responsible for the care of each resident. She stated all CNAs were encouraged to read the residents' care plans and know what interventions had been put in place. LNG stated each day before shift nursing staff meet for a High Five meeting to discuss any changes. On 07/08/2026 at 12:36 PM, Administrative Nurse D stated all nursing staff have access to all residents' care plans. She stated it was all nursing staff's responsibility to ensure interventions were in place before leaving a resident's room. Administrative Nurse D stated if a resident's heel needed floated it would also be on the EMR under the Treatment Administration Record (TAR). The facility's Pressure Injury Prevention and Management policy, dated 10/13/2025, documented the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.		

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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. Based on observations, record review, and interviews, the facility failed to ensure Resident (R)12's fall preventions were in place. Findings included:- R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN-elevated blood pressure), chronic pain, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Modification of Significant Change Minimum Data Set (MDS) for R12, dated 05/12/2026, recorded a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R12 was dependent on staff for toileting and bathing. The MDS documented R12 had two or more non injury falls since admission or re-entry during the observation period. The Fall Care Area Assessment, dated 05/12/2026, documented R12 had a history of falls and received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medication, and increased her risk for impaired safety, dizziness, sedation, and recurrent falls. The CAA documented R12 required ongoing monitoring and fall prevention interventions. R12's Care Plan documented the following fall interventions: 03/05/2025 - Nonskid strips were to be placed under R12's recliner. 05/18/2026 - R12 was at risk for falls related to being unable to ambulate long distances and would need a wheelchair. 08/13/2025 - Staff were to encourage R12 to wear her Sketcher tennis shoes. 08/18/2025 - A low bed with scoop mattress, and call light trigger pad to be placed in R12's bed. 10/30/2025 - Keep R12's wheelchair within her reach. 12/01/2025 - R12 was to be assisted to her recliner after meals. 01/12/2026 - R12 would be toileted mid-morning when she declines early morning rising. 02/17/2026 - Physical therapy and Occupational therapy to treat if indicated. R12's Fall Risk Assessment dated 02/17/2026 documented a score of 14, indicating R12 was at risk. On 07/07/2026 at 07:52AM, R12 laid on her bed; the head of the bed was raised. R12's eyes were shut, and her bed was at waist height. R12's bed was not in a low position. On 07/08/2026 at 07:42 AM, R12 laid on her bed with her eyes shut. R12's bed was at waist height. R12's bed was not in a low position. On 07/08/2026 at 10:39 AM, Certified Nurse Aide (CNA) M stated that if there was a change in interventions, her nurse would let her know. She stated if a resident was a fall risk, the resident's door would have a leaf outside the resident's room. CNA M stated it was CNA's responsibility to ensure all residents' fall interventions were in place before leaving the residents' room. On 07/08/2026 at 10:47 AM, Licensed Nurse (LN) G stated all nursing staff were responsible for the care of each resident. She stated all CNAs were encouraged to read the residents' care plans and know what interventions had been put in place. LN G stated each day before shift, nursing talks about any changes with residents. On 07/08/2026 at 12:36 PM, Administrative Nurse D stated all nursing staff have access to all residents' care plans. She stated it was all nursing staff's responsibility to ensure interventions were in place before leaving a resident's room. The facility's Fall Prevention Program, dated 10/2025, documented each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.		