STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175263	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Olathe	20705 W 151st Street Olathe, KS 66061

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. The facility identified a census of 123 residents with one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to food storage and food temperature checks. This deficient practice placed the residents at risk related to foodborne illnesses and food safety concerns.Findings included:- On 07/21/24 at 07:00 AM, a walkthrough of the facility's secured 100 Hall was completed. An inspection of the unit's kitchenette refrigerator revealed uncovered and labeled food plates from the previous evening's dinner on the top two shelves. The refrigerator had food residue on the inside of the walls. An inspection of the Juice machine area revealed a cup caked in pink drink mix residue in a drawer directly under the juice fountain.On 07/21/25 at 07:28 AM, an observation in the kitchen's dry food storage room revealed a bread storage cart. The bread storage car had a sign that documented when bread was pulled from the freezer, staff were to mark it with a date and use that bread within seven days, no exceptions.On 07/21/25 at 07:29 AM, an observation in the kitchen's dry food storage room, on the bread storage cart, revealed one opened package of hamburger buns. The bag was not dated. On 07/21/25 at 07:29 AM, an observation in the kitchen's dry food storage room, on the bread storage cart, revealed one opened loaf of bread. The bag was not dated. On 07/21/25 at 07:30 AM, an observation in the kitchen's dry food storage room, on the bread storage cart, revealed one bag of hot dog buns. The bag contained six hot dog buns. Three of the buns had visible mold on them.On 07/21/25 at 07:31 AM, an observation in the kitchen's dry food storage room, on the bread storage cart, revealed two open bags of hot dog buns. The bags were not dated.On 07/21/25 at 07:35 AM, an observation in the kitchen's dry food storage room revealed two opened bags of noodles. One bag was wrapped with plastic wrap, and one bag was open to the air. The bags were not dated.On 07/21/25 at 07:37 AM, an observation in the kitchen's dry food storage room revealed one opened bag of yellow cake mix. The bag did not have a date.On 07/21/25 at 07:51 AM, an observation in the main kitchen area revealed a refrigerator labeled as refrigerator three. A plastic container was observed inside of refrigerator three. The plastic container contained two hard-boiled eggs. The container was not labeled or dated.On 07/21/25 at 07:52 AM, an observation in the main kitchen area revealed a refrigerator labeled as refrigerator two. Refrigerator two contained 10 unopened bags of French toast and one unopened bag of pancakes. The bags were unlabeled, had no manufacturer information on the packaging, and had no date.On 07/21/25 at 08:00 AM, an observation in the Walk-In refrigerator unit revealed two half-gallons of 2% milk. The two half-gallons of milk were opened and had no date.On 07/21/25 at 08:01 AM, an observation in the Walk-In refrigerator unit revealed one opened bag of red grapes. The bag had no date.On 07/21/25 at 08:05 AM, an observation in the Walk-In freezer unit revealed one bag of frozen tater tots. The bag was opened and had no date.On 07/21/25 at 08:05 AM, an observation in the Walk-In freezer unit revealed one bag of frozen onion rings. The bag was open to air and had no date.On 07/21/25 at 11:07 AM, Dietary CC checked the temperatures for food as it was taken from the oven and moved to the steam table. Dietary CC took a dish towel and ran it under the water from the sink. Dietary CC was not observed performing hand hygiene prior to wetting the dish towel. Dietary CC wrung the excess water out with his hand and brought the towel to the prep table. Dietary CC placed the towel on the (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	table and used it to wipe the thermometer off between checking each food item taken from the oven. Dietary CC placed the thermometer on the food prep table, where the probe would touch the table. Dietary CC also checked food temperatures for food being served from the steam table for lunch. Dietary CC took the dish towel to the steam table and continued to use it to wipe the thermometer probes between food items. On 07/22/25 at 07:54 AM, on the facility's secured 100 Hall CNA N labeled and placed breakfast plates for R2, R71, R102, and R104 directly in the refrigerator on the unit's kitchenette. CNA N placed the plates in the refrigerator briefly, without covers, and closed the refrigerator.On 07/21/25 at 11:25 PM, Dietary BB stated he had only been at the facility for a week so far. Dietary BB stated that any food items that had been opened should have been covered, labeled, and dated. Dietary BB stated bags should not have been left open, and he would use a resealable bag for food items like that. He further stated that when items were taken out of a box, they would need to be labeled. Dietary BB further stated that any blank manufacturer bags should have dates placed on them. Dietary BB stated that when temping food, staff should have wiped the thermometer probes with disposable sanitation wipes they had in the kitchen and not a towel. Dietary BB stated staff should wash their hands between tasks, touching other items, and moving to different locations.The facility's Food-Supply Storage- Food and Nutrition Services policy, with a reviewed/revised date of 03/07/25, documented the use of the principle of First-In, First-Out (FIFO) in all areas of food and drink storage for the rotation of food items. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled, and stored properly. Stock items are individually dated with the delivery date if removed from the original container.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility had a census of 123 residents. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to secure chemicals in a safe, locked area, and out of reach of the twelve cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents.Finding included:- On 07/21/25 at 07:05 AM, an initial walkthrough of the facility revealed an unsecured exam room on the 300 Hall. An inspection of the exam room revealed a container of purple disinfectant wipes on the counter. The label on the wipes contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed.On 07/21/25 at 10:00 AM, an inspection of the facility's secured 100 Hall revealed a kitchenette area. An inspection of the kitchenette revealed a container of purple disinfecting wipes in the cabinet underneath the sink. The label on the wipes contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed. Certified Nurse Aid (CNA) N stated the wipes were to be in a locked closet and moved them to the nurse's station.On 07/23/25 at 01:09 PM, Licensed Nurse (LN) G stated that staff were expected to lock up cleaning products and ensure they remained out of reach for the residents.On 07/23/25 at 01:30 PM, Administrative Nurse D stated that cleaning products and areas with potential hazards should always be locked.The facility's Accidents policy, revised 04/2025, stated the facility would ensure a safe environment for all residents. The policy indicated staff would assess each resident's potential risks, including functional abilities, potential falls, assistive devices, and environment, to ensure resident safety.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 123 residents. The sample included 24 residents, with one resident reviewed for dignity. Based on observation, record review, and interviews, the facility failed to provide services in a dignified manner for Resident (R) 31 when staff stood over R31 while feeding her a yogurt cup. This deficient practice placed R31 at risk for impaired dignity and decreased psychosocial well-being.Findings included:- R31's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), bradycardia (low heart rate, less than 60 beats per minute), difficulty walking, and abnormalities of gait and mobility.The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R31 needed set up or cleanup for eating, set up or cleanup for oral hygiene, substantial to maximal assistance with toileting, and dependent on staff for bathing and personal hygiene. R31's Functional Abilities (self-care mobility) Care Area Assessment (CAA) dated 11/06/24 documented R31 needs assistance with activities of daily living (ADL).R31's Care Plan dated 04/20/25 documented R31 had an ADL self-care performance deficit related to dementia and needed assistance with ADLs. R31's plan of care documented that the staff were to assist with bedtime cares, offer a wheelchair if R31 was weak, and toilet her before going to bed. The plan of care documented staff were to ensure R31 got from the dining room to her room after meals.On 07/21/24 at 08:11 AM, R31 was sitting in her wheelchair in her room. The CNA O was in her room, standing over her bedside table, feeding R31 yogurt. The CNA O stated she was told to help her with her meal, that R31 had difficulty eating by herself.On 07/23/25 at 12:48 PM, Certified Nursing Aide (CNA) M stated that staff could stand or sit to help residents needing assistance to eat. She stated it was better to sit down and talk to the resident if they were feeding them.On 07/23/25 at 01:00 PM, Licensed Nurse (LN) G stated that staff should sit next to the resident if they fed that resident. She stated CNA O should never stand over a resident to feed them.On 07/23/25 at 01:48 PM, the Administrative Nurse D staff should sit next to the resident and talk to the resident. Staff should never tower over a resident while they are feeding them.The facility's Resident Dignity policy dated 12/11/24 documented that the location would promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 123 residents. The sample included 24 residents. One resident was sampled for reasonable accommodations of the resident's needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 38's call light was within his reach. This deficient practice left R38 vulnerable to unmet care needs due to the inability to call for staff assistance.Findings included:- R38's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), psychotic disturbance (a loss of touch with reality characterized by altered thinking, perceptions, and behavior), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), bradycardia (low heart rate, less than 60 beats per minute), repeated falls, need for assistance with personal care, lack of coordination, neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), muscle weakness, dysphagia (swallowing difficulty), pain, and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R38 was dependent on staff for toileting, bathing, and dressing, and required partial to moderate assistance from staff for eating.R38's Cognitive/Loss Dementia Care Area Assessment (CAA) dated 09/11/24 documented R38 was unable to complete a BIMS score. The CAA documented R38 had reported short-term and long-term memory problems. The CAA documented R38 could not make decisions regarding daily life. The CAA documented R38 was severely impaired and had physical and verbal behaviors toward others.R38's Care Plan dated 09/04/24 documented R38 had a communication problem related to hearing deficit, dementia, and rarely speaks. R38's plan of care documented that the staff were to encourage R38 to continue stating thoughts even if he was having difficulty. R38's plan of care documented that the staff were to encourage verbalizing frustrations versus physical action. R38's plan of care lacked staff direction regarding his call light placement.On 07/21/25 at 07:35 AM, R35 sat in her room in his Broda chair (specialized wheelchair with the ability to tilt and recline). R38's call light laid on the floor between his bed and his Broda chair. R38 was unable to reach his call light.On 07/23/25 at 12:48 PM, Certified Nurse's Aide (CNA) M stated that call lights should always be within the resident's reach.On 07/23/25 at 01:00 PM, Licensed Nurse (LN) G stated that call lights should be in the resident's reach. LN G stated that placing call lights was the last thing the CNAs were trained to do before walking out of a resident's room.On 07/23/25 at 01:38 PM, Administrative Nurse D stated the resident's call light should be placed anywhere the resident can reach the light. Administrative D stated that some residents can knock their call lights on the floor, out of their reach.The facility's Call light policy dated 07/08/25 documents ensure residents always have a method of calling for assistance, and staff promptly answer residents' call lights. When the facility has a new admission, explain and demonstrate the use of the call light system. When a resident's call light is observed/heard, go to the resident's room promptly and respond to the request as soon as possible. Turn the call light off and inquire about the resident's request. When leaving the room, place the call light within easy reach of the resident. For residents unable to use the call light, care plan appropriate interventions, and provide an adaptive call light if applicable.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. The facility identified a census of 123 residents. The sample included 24 residents, with one resident reviewed for abuse and neglect. Based on observation, record review, and interviews, the facility failed to report an unwitnessed injury fall of Resident (R) 58 (severely cognitively impaired), resulting in emergency medical treatment to the state investigative agency. This placed the residents at risk for potentially unidentified and ongoing abuse and /or neglect.Findings included:- The Medical Diagnosis section within R58's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (difficulty sleeping), muscle weakness, and abnormal gait/mobility.R58's Significant Change Minimum Data Set (MDS) completed 06/06/25 noted a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS noted she required substantial to maximal assistance with dressing, toileting, footwear, and personal hygiene, but could transfer and ambulate with supervision. The MDS indicated she was a fall risk and had a history of falls. R58's Cognitive Impairment Care Area Assessment (CAA) completed 06/12/25 indicated she had severe cognitive impairment related to her medical diagnoses, and a care plan would provide interventions to minimize the risks associated with her impairment.R58's Falls CAA completed 06/12/25 indicated she was at risk for falls related to her cognitive impairment, unsteady balance, and history of fracture (broken bone) related falls. The CAA noted she was not able to recognize her physical limitation and postural instability. The CAA noted that a care plan would provide interventions to minimize the risks associated with her impairment.R58's Care Plan initiated 11/08/24 indicated she was at risk for falls, impaired communication, a decrease of activities of daily living (ADL), and elopement due to her medical diagnoses. The plan noted she required staff assistance for bathing, toileting, and dressing. The plan noted she could ambulate (walk) and transfer without assistive devices or staff assistance. The plan noted she had fallen on 05/31/25, resulting in a maxillary/sinus (left facial fracture) while walking down the hallway. The plan instructed staff to remind R58 of her limitations during walking and offer breaks while ambulating around the unit. The plan indicated R58 had non-slip strips applied to her floor on 06/26/25 after an injury fall.R58's EMR under Progress Notes revealed she had an unwitnessed fall in her room on 06/26/25 at 01:10 PM. The note revealed that staff heard R58 yelling for help in her room. The note revealed that staff found R58 on the floor, partially on her back. The note revealed R58 had a contusion (bruising under skin) on the right side of her forehead and bleeding. The note revealed R58 could not communicate to the staff what happened or how her injuries occurred. The note revealed she was sent out to an acute medical facility for treatment.R58's EMR under Progress Notes revealed an Interdisciplinary Team (IDT) note dated 06/27/25, which revealed she received two staples at the top of her head and returned to the facility with no new fractures.A facility investigation completed on 06/06/25 revealed a root cause analysis noted R58 probably tried to get out of bed and slipped on the hardwood floor. The investigation indicated non-slip strips were added to the floor next to her bed to prevent future falls. The report lacked an indication that the unwitnessed injury fall was reported to the state investigating agency for review.R58's EMR revealed no documentation showing prior injuries to R58's forehead, scalp, or top of her head prior to her fall on 06/26/25.On 07/22/25 at 09:01 AM, an inspection of R58's room revealed her bed in the low position. Non-slip strip around her bed and toileting area. R58's toilet had grab bars installed to prevent toileting falls. On 07/23/25 at 09:14 AM, Administrative Nurse D stated the facility did not report the incident because she felt it was just a fall. She stated the facility was required to report injuries of unknown origin, but didn't think the fall was reportable. She stated the facility holds annual and periodic trainings related to reporting abuse, neglect, and exploitation for cognitively impaired residents.The facility's Abuse and Neglect policy, revised 07/2024, would educate, prevent, identify, and report all potential abuse, neglect, and exploitation allegations within the guidelines set by the facility, state investigatory agency, and federal guidelines.

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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 identified a census of 123 residents. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to ensure a bed hold and notification was provided to Resident (R) 1, and her representative was provided with a bed hold policy that included the facility's per diem rate to hold a bed. The facility failed to ensure R1 and her representative were provided a written notification of transfer upon her transfer to the hospital. This placed R1 at risk of miscommunication between the facility and the resident's representative, and the possible missed opportunity for healthcare services.Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of hypertension (elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), cerebrovascular disease (CVA- 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), and dementia (a progressive mental disorder characterized by failing memory and confusion).R1's Discharge Minimum Data Set (MDS) dated 10/08/24 documented an unplanned discharge to an acute hospital with a return anticipated.R1's Entry MDS dated 10/14/24 documented a re-entry to the facility from an acute hospital.R1's Discharge MDS dated 04/08/25 documented an unplanned discharge to an acute hospital with a return anticipated.R1's Entry MDS dated 04/11/25 documented a re-entry to the facility from an acute hospital.R1's Significant Change MDS dated 04/18/25 documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 required partial to substantial assistance from staff for her activities of daily living (ADL). The MDS documented R1 was dependent on staff for toileting, and R1 required the use of a walker and a wheelchair for mobility. R1's Functional Abilities Care Area Assessment (CAA) dated 04/25/25 documented she needed assistance with ADLs.R1's Care Plan, last revised on 03/25/25, directed staff that she wished to remain at the facility for long-term care. The Care Plan directed staff to encourage her to discuss her feelings and concerns regarding R1's advanced directives. The facility failed to provide a written notification of transfer and a bed hold policy to R1 and her representative before her transfer to the hospital on [DATE].The facility failed to provide a written notification of transfer and a bed hold policy to R1 and her representative before her transfer to the hospital on [DATE].On 07/22/25 at 08:15 AM, R1 sat in her wheelchair in the dining room eating breakfast. R1 stated she had not received the bed hold policy before she went to the hospital.On 07/23/25 at 02:30 PM, Administrative Staff A stated that he was unable to locate the bed hold and notification of transfer for R1's transfer to the hospital on [DATE] and 04/08/25.On 07/23/25 at 01:38 PM, Administrative Nurse D stated that initially, the nurse should complete the bed hold and notification of transfer paperwork before a resident was sent to the hospital. Administrative Nurse D stated that social services was responsible for notifying the representative and following up on the bed hold and notification of transfer.The facility's Bed-Hold Rehab/Skilled policy, revised on 12/19/24, documented at the time of admission, transfer or therapeutic leave, the location would provide written information to the resident or resident representative that specified the duration of the state bed-hold policy, if any, during which a resident was permitted to return and resume residence. The reserve bed payment policy in the state plan. The location's policies regarding bed-hold periods permit a resident to return. The resident's copy of the Notice of Bed-Hold Policy was sent with the other papers accompanying the resident to the hospital. The family member or resident representative, if any, is provided with the Notice of Bed-Hold Policy within 24 hours of the transfer. The Notice of Bed-Hold Policy should be mailed if the family or the resident representative did not come to the facility to receive a copy. The charge nurse was responsible for the completion of notification procedures if the transfer occurred at a time when the social worker was not at the location. The social worker or designated individual will contact the resident/resident representative (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to inquire regarding their decision to hold a bed. In cases where the facility was unable to notify the resident representative, the social worker or designated individual will document multiple attempts to reach the resident's representative.The facility's Notification of Change policy, revised on 12/23/24, documented a facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s) when there was: A decision to transfer or discharge the resident from the facility for one of the following reasons: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. When the facility transfers or discharges a resident under any of the circumstances specified, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving healthcare institution or provider.

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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 123 residents. The sample included 24 residents, with four residents reviewed for activities of daily living (ADL) for dependent residents. Based on observation, record review, and interviews, the facility failed to ensure a shower/bath was provided for Resident (R) 52, who was dependent on staff assistance with ADLs. This deficient practice had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial well-being.Findings included:- R52's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of muscle weakness, need for assistance with personal care, abnormalities of mobility, and cancer of the endometrium (mucous membrane that lines the uterus).The Significant Change Minimum Data Set (MDS) dated 05/30/25 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R52 required substantial to maximum staff assistance with bathing, transfers, bed mobility, and personal hygiene during the observation period.R52's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 05/31/25 documented she required assistance with her ADLs.R52's Care Plan, last revised on 10/01/24 documented she required assistance with bathing and would offer to assist her with shaving.R52?s EMR under the Reports tab and Bathing task was reviewed for the following dates: 05/01/25 to 07/21/25 (81 days). The EMR documented three non-facility staff provided (NF) on 05/07/25, 05/14/25, and 06/08/25, three Whirlpool (W) were documented on 05/29/25, 06/04/25, and 06/11/25, one Sponge Bath (Sp) on 06/21/25, and one Shower (SH) on 06/18/25. The EMR documented Not Applicable (97 not applicable) on 05/28/25 and 06/07/25, one Did Not Occur (DO) onmn06/22/25, and four Resident Refused (98 resident refused) on 06/11/25, 06/14/25, 06/28/25, and 07/16/25. The facility provided a bath log for R52, which was not part of her EMR. The facility provided a printed report from the Tasks tab for the past 30 days, which documented on 06/25/25 R52 refused her bath, on 07/16/25 R52 refused her bath, on 07/19/25 non-facility staff provided R52 a bath, and on 07/23/25 R52 was provided a sponge bath.On 07/21/2025 at 11:03 AM, R52 sat in her wheelchair in her room. R52's room had an odor of urine.On 07/22/25 07:43 AM, R52 was asleep on her bed. R52's room had an odor of urine noted next to the bed and wheelchair.On 07/23/25 at 07:22 AM, R52 was asleep on her bed in the low position, and an odor of urine was not next to the bed.On 07/23/25 at 08:50 AM, Certified Nurse Aide (CNA) P stated R52 did not usually refuse her baths/showers. CNA P stated R52 was incontinent of bladder. CNA P stated her room had a urine smell in the carpet and on the bed, because she removed her soiled incontinent brief, placed it on the floor in the mornings, and then was incontinent of her bladder on the mattress.On 07/23/25 at 09:10 AM, Licensed Nurse (LN) H stated R52 was incontinent of bladder. LN H stated she was aware that R52 would remove her soiled incontinent brief at times and place the brief on the floor. LN H stated R52's room had a urine odor from her bed and carpet. LN H stated R52's room should have the carpet removed. LN H stated R52 seldomly refused her bath. LN H stated CNA P was usually the staff member that R52 wanted to provide her bathing activity.On 07/23/25 at 01:40 PM, Administrative Nurse D stated that each resident had an assigned bath day. Administrative Nurse D stated that the list was located on the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), on the resident's plan of care, and there was a master list kept at the nurse's station. Administrative Nurse D stated she would expect the nursing staff to offer a resident a bath several times if they had refused. Administrative Nurse D stated that the staff should notify the charge nurse when a resident refused their bath. Administrative Nurse D stated that the charge nurse should attempt to find out why the resident had refused their bath, and the refusal of a bath should be documented in the resident's EMR.The facility's Activities of Daily Living policy dated 12/23/24 documented that any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on the resident's comprehensive assessment, the center would ensure the resident's ability in activities of (continued on next page)

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Good Samaritan Society - Olathe	20705 W 151st Street Olathe, KS 66061

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily living (ADL) does not decline except when unavoidable for reasons of disease progression, deterioration of physical condition associated with disability, or refusal of care/treatment by the resident or legal representative. Evidence of any of these reasons would be reflected in the medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 123 residents. The sample included 24 residents, with one resident reviewed for quality of care. Based on observation, record review, and interview, the facility failed to complete weekly wound assessments, including wound measurements, for Resident (R) 11's right knee wound. This placed R11 at increased risk for worsening pressure or skin injuries and delayed wound recovery. Findings included:- R11's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of muscle weakness, need for assistance with personal care, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and open wound on right knee.The Significant Change Minimum Data Set (MDS) dated 12/18/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R11 required substantial to maximum staff assistance for dressing upper body and mobility. The MDS documented R11 required partial to moderate staff assistance for personal hygiene. The MDS documented R11 was dependent for staff assistance for transfers, toileting, and lower body dressing. The MDS documented R11 was at risk for development of pressure related injuries. The MDS documented R11 had an open lesion during the observation period. The MDS documented the facility provided a pressure reducing device for her bed and chair. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R11 was dependent on staff assistance for transfers, bathing, bed mobility, dressing, and toileting. The MDS documented R11 was at risk for development of pressure related injuries and the facility would provide pressure reducing devices on her bed and chair. The MDS documented R11 had application of nonsurgical dressings and applications of ointments/medications other than to feet during the observation period.R11's Pressure Ulcer Care Area Assessment (CAA), dated 12/26/24 documented she was at risk for pressure ulcers.R11's Care Plan with an initiated date of 07/29/24, documented R11 had actual impairment to skin integrity to peri area (the region of the body between the anus and the external genitals) and buttocks. The Care Plan with an initiated date of 07/22/24, documented R11 had potential for pressure ulcer development related to decreased mobility.Review of the assessment tab of R11's EMR documented the following:Two entries for Wound Register Nurse (RN) assessment dated 12/14/24 and 01/07/25. The listed type for the two assessments were documented as coccyx (area at the base of the spine). No other Wound RN Assessments were documented in R11's EMR after 01/07/25. Two entries for Wound Data Collection dated 12/13/24 and 12/16/24. The listed type for the two assessments were documented as coccyx. No other Wound Data Collection assessments were documented in R11's EMR after 12/16/24.A Skin Observation assessment dated [DATE], documented a skin check was completed with no skin conditions observed or skin condition resolved. A note in the assessment documented no new skin observations. The assessment lacked any documentation related to R11's right knee wound.A Skin Observation assessment dated [DATE], documented all other skin observations noted with a note box that documented top of R11's left foot had a superficial skin abrasion noted by Physical Therapy (PT) staff. The assessment note further documented there was no redness or open skin noted. The assessment lacked any documentation related to R11's right knee wound.There were no further Skin Observation assessments documented after 05/09/25, in R11's EMR.Review of R11's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 06/01/25 to 06/30/25 documented right knee skin prep every day and evening shift for area. Start date 06/10/25 and discontinue date of 07/01/25. The order was documented as done each shift starting the evening of 06/10/25 to the evening of 06/22/25. Entries starting 06/23/25 to 06/30/25 were documented as R11 being hospitalized .Review of R11's MAR and TAR dated 07/01/25 to 07/31/25 documented to right knee: cleanse with normal saline (NS- saline water solution for medical use), apply medihoney (used in wound care to promote healing) and cover with bordered foam (a type of wound dressing that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combines a highly absorbent foam layer with an adhesive border). Change every other day and as needed, with a start date of 07/02/25. The order was documented as done each shift starting on 07/02/25 day shift to 07/22/25 on evening shift.R11's EMR lacked evidence that wound assessments or measurements were done for R11's right knee wound from 06/10/25 to 06/22/25 prior to her hospitalization. R11's EMR lacked evidence wound assessments or wound measurements were done for R11's right knee wound from 07/02/25 to 07/22/25 after she had returned to the facility from the hospital.A Provider/Practitioner note with an effective date of 07/21/25 and a created date of 07/23/25 was marked as a late entry. The note documented R11 had a chronic wound to her right knee that remained stable or unchanged. The note further documented the wound had been present without complete healing for greater than one year and prior to initial admission at the facility. The note documented R11's abrasion (scraping or rubbing away of skin) to her right knee had not healed. The note further documented current dressing protected area and the writer documented they did not expect the area to close. The note documented R11 was followed by outpatient wound center and released. The note further documented continue to monitor to assure stability and no infection.The note lacked any wound measurements.On 07/24/25 the facility provided an untitled document, from R11's hospital stay, dated 06/23/25 that documented wound measurements to R11's right knee. The document recorded a wound length of 2.7 centimeters (cm), wound width 2.2 cm, and a wound depth of 0.1 cm.On 07/21/25 at 10:00 AM, R11 rested in her bed. R11 stated she had a wound to her right knee. R11 stated she had the wound so long she did not remember where it came from. She stated she thought it rubbed on the Hoyer (full body mechanical lift) sling and that may have kept it from healing.On 07/23/25 at 11:28 AM, Licensed Nurse (LN) J stated measurements, and wound assessment should have been documented under the Wound Data Collection assessment every time her wound was assessed. LN J stated there should have been measurements documented for R11's knee wound. On 07/23/25 at 01:03 PM, LN G stated weekly skin assessments was documented on the resident's TAR and the only time a skin assessment would have been documented in further detail would be if a new skin condition was found. LN G stated LN J normally does the wound assessment and measurements for the facility, but she has recently switched her hours to part time and another nurse had taken over her role. LN G stated wound measurements should have been documented in the Wound Data Collection assessments. LN G sated she thought since the wound doctor was not following R11's knee wound weekly, that the wound measurements were not being done. She was not sure how often the wound nurse measured the wounds. LN G stated R11 has had the wound for a long time. LN G stated in the past, the facility would get the wound to close; however, R11's wound would often reopen after she returned to the facility from a hospital stay. LN G stated she believed R11's knee wound has been opened for at least the last month. LN G stated she believed R11's doctor was monitoring her knee wound.On 07/23/25 at 01:38 PM, Administrative Nurse D stated resident's skin and pain assessments were documented on the TAR and documented in further detail if a new wound was found. Administrative Nurse D stated wound measurements and assessment were done weekly. Administrative Nurse D stated LN J had to change her hours to as needed and another nurse was assuming her role. She stated some of the transition had occurred during the time R11's wound measurements were not documented. Administrative Nurse D stated the wound assessments and measurements were supposed to be done even if the wound doctor was not following the wound directly. Administrative Nurse D stated R11 should have had measurements documented for her knee wound. The facility's Skin Assessment Pressure Ulcer Prevention policy dated 04/06/25 documented the purpose of the policy was to systematically assess residents regarding risk of skin breakdown. Nursing was to accurately document observations and assessments of residents. Nursing was to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers. Assessment and documentation of bruises, contusion (bruise), skin tears, or abrasion (scraping or rubbing away of skin). A bruise or contusion was an injury when the skin was not broken. Pain, swelling, and discoloration was characteristic. A skin tear was a traumatic injury to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the skin that results in separation of outer layers of the skin. An abrasion was a wound caused by superficial damage to the skin, no deeper than the epidermis (superficial layers of the skin). If a bruise, contusion, abrasion, or skin tear was observed on a resident, this should be reported to the nurse immediately. The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation user Defined Assessment (UDA) and on the resident's care plan. The nurse should also document a Braden Scale UDA for predicting pressure sore risk Positioning Assessment and Evaluation UDA, Skin Observation UDA, Wound Data Collection UDA, and Wound Registered Nurse Assessment UDA.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 123 residents. The sample included 24 residents, with three residents reviewed for treatment and services to prevent or heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to effectively implement interventions to reduce the risk or promote healing of pressure injuries for Resident (R) 74 and R31, the facility further failed to ensure R3's offloading boots were placed on his heels. This placed R74, R31, and R3 at increased risk for pressure ulcer development.Findings included:- R74's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), history of falls, major depressive disorder (major mood disorder that causes persistent feelings of sadness), need for assistance with personal care, communication deficit, urge incontinence (involuntary passage of urine occurring soon after a strong sense of urgency to void), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented that R74 was at risk for developing pressure ulcers. The MDS documented R74 had a pressure-reducing cushion in her chair and bed, and a turning repositioning program. The MDS documented R74 had an unstageable wound due to a non-removable dressing. The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 04/09/25 documented R25 was incontinent of bowel and bladder. The CAA documented that R74 had a cushion on her wheelchair and a pressure relief mattress on her bed. The CAA documented that R74 would not wear boots because she walks and transfers herself. R74's Care Plan dated 05/07/25 documented R74 had an unstageable pressure area on the left heel related to decline. The plan of care documented that the staff were to assess, record, and monitor the healing weekly. The plan of care documented staff were to report improvements and declines to the health care provider. The plan of care for R74 documented facility was to provide a cushion for her wheelchair, a pressure relief mattress on her bed, and a pillow under her feet at night. The plan of care for R74 documented that the facility was to provide supplemental protein, and staff were to notify the nurse immediately of any new area of skin breakdown. R74's Wound Data Collection Assessment dated 07/21/25 documented R74 had 0.5 centimeters (cm) in length and 0.9 cm in width area of eschar (dead tissue) to the left heel. Skin-prep (liquid skin protectant) would be applied to the heel. R74's Braden Scale for Prediction Pressure Sore Risk dated 07/01/25 documented 15, which indicated a mild risk for pressure ulcer. R74's EMR under the Orders tab revealed the following physician orders: R74 offload heels in bed with a pillow-no heel boots/protectors due to fall risk every shift for unstageable pressure ulcer, dated 04/14/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complete daily wound data for the left heel (wound nurse will do weekly measurement) every evening shift for the unstageable pressure ulcer, dated 04/15/25. On 07/21/25 at 07:36 AM, R74 lay in her bed, on her back. R74's heels lay directly on her mattress. On 07/22/25 at 08:05 AM, R74 lay in her bed on her back. R74's heels lay directly on her mattress. On 07/23/25 at 12:48 PM, Certified Nurse's Aide (CNA) M stated that if a resident needed their heels floated, nurses were to ensure that heels were floated. CNA M stated that the floating of a resident's heel was on the Treatment Administration Record, and she stated that it was a nursing duty. On 07/23/25 at 01:00 PM, Licensed Nurse (LN) G stated the CNAs and nursing staff were to ensure the residents' heels were floated. LN G stated that the floating of heels was on the nursing TAR but was also on the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). She stated that all nursing staff are responsible for ensuring the residents are taken care of. On 07/23/25 at 01:38 PM, Administrative Nurse D stated it was all the nursing staff's responsibility to ensure heels were floated. Administrative Nurse D stated that floating of heels was on the Kardex for CNAs to see and was on the TAR as a second check. The facility's Skin Assessment Pressure Ulcer Prevention policy dated 04/06/25 documented that the purpose of the policy was to systematically assess residents regarding risk of skin breakdown. Nursing was to accurately document observations and assessments of residents. Nursing was to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers. - R31's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), bradycardia (low heart rate, less than 60 beats per minute), difficulty walking, and abnormalities of gait and mobility. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R31 was at risk for pressure ulcer/injury. The MDS documented R31 had a pressure-reducing device for her chair and bed. The MDS documented R31 had a turning/reposition program, nutrition and hydration, and pressure ulcer injury care. R31's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 11/06/24 documented R31 had a new Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters). The CAA documented R31 declined offloading boots, and staff were to elevate her legs. R31 had a cushion on her wheelchair and a pressure relief mattress on her bed. R31's Care Plan dated 06/10/25 documented R31 had a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer related to a decrease in mobility. The plan of care for R31 documented she had a history of an open area on her left heel, currently had an area on her sacrum, an open area on her left great toe, and an open area on her right knee. The plan of care for R31 documented staff would reposition her every two hours, encourage her to shift in her wheelchair, and encourage her to lay down in the afternoon. The plan of care documented staff were to provide a low air loss mattress with bolsters and heel protectors as tolerated, R31 preferred (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pillows for offloading her heels in bed, and a cushion for her wheelchair. R31s Braden Scale for Prediction Pressure Sore Risk dated 07/15/25 documented a score of 13, indicating a moderate risk for pressure ulcers. R31's Weekly Wound Assessment dated 07/21/25 documented R31 had wounds to the right and left great toes and sacrum. R31's physician's orders under the Orders tab revealed the following orders: Left heel: Cleanse with normal saline and apply Skin-prep (liquid skin protectant) to the surrounding area, then apply a bordered foam (foam dressing), change every day shift, every Monday and Thursday, to maintain skin integrity, dated 05/05/25. On 07/21/25 at 08:25 AM, R31 lay on her bed; R31's heels lay directly on her mattress. On 07/23/25 at 12:48 PM, Certified Nurse's Aide (CNA) M stated that if a resident needed their heels floated, nurses were to ensure that heels were floated. CNA M stated that the floating of a resident's heel was on the Treatment Administration Record, and she stated that it was a nursing duty. On 07/23/25 at 01:00 PM, Licensed Nurse (LN) G stated the CNAs and nursing staff were to ensure the residents' heels were floated. LN G stated that the floating of heels was on the nursing TAR but was also on the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). She stated that all nursing staff are responsible for ensuring the residents are taken care of. On 07/23/25 at 01:38 PM, Administrative Nurse D stated it was all the nursing staff's responsibility to ensure heels are floated. Administrative Nurse D stated that floating of heels was on the Kardex for CNAs to see and was on the TAR as a second check. The facility's Skin Assessment Pressure Ulcer Prevention policy dated 04/06/25 documented the purpose of the policy was to systematically assess residents regarding risk of skin breakdown. Nursing was to accurately document observations and assessments of residents. Nursing was to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers. - R3's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, and pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) on right heel. The admission Minimum Data Set (MDS) dated 03/05/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R3 required substantial to maximum staff assistance with personal hygiene, partial to moderate staff assistance with bed mobility, and was dependent on staff assistance with transfers. The MDS documented R3 was at risk for pressure-related injuries. The MDS documented that R3 had an unhealed pressure ulcer during the observation period. The MDS documented R3 had pressure-reducing devices on the bed and in the chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS dated [DATE] documented a BIMS score of 13, which indicated intact cognition. The MDS documented that R3 required substantial to maximum staff assistance for personal hygiene and transfers, and partial to moderate staff assistance with bed mobility. The MDS documented R3 was at risk of pressure-related injuries and had an unhealed pressure ulcer during the observation period. The MDS documented R3 had a pressure-reducing device on the bed and in the chair. R3's Pressure Ulcer Care Area Assessment (CAA), dated 03/13/25, documented that he had a pressure ulcer on his right heel. R3's Care Plan, last revised 03/18/25, documented that the facility would provide a low-air-loss mattress on his bed, a cushion in his wheelchair, and offloading boots as tolerated. On 07/23/25 at 09:32 AM, R3 lay on the bed, head of bed elevated with his bedside table across the bed. R3's right heel rested directly on the mattress, and a pressure-reducing boot was on the floor at the floor next to the bed. On 07/23/25 at 12:48 PM, Certified Nurse's Aide (CNA) M stated that if a resident needed their heels floated, nurses were to ensure that heels were floated. CNA M stated that the floating of a resident's heel was on the Treatment Administration Record, and she stated that it was a nursing duty. On 07/23/25 at 01:00 PM, Licensed Nurse (LN) G stated the CNAs and nursing staff were to ensure the residents' heels were floated. LN G stated that the floating of heels was on the nursing TAR but was also on the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). She stated that all nursing staff are responsible for ensuring the residents are taken care of. On 07/23/25 at 01:38 PM, Administrative Nurse D stated it was all the nursing staff's responsibility to ensure heels are floated. Administrative Nurse D stated that floating of heels was on the Kardex for CNAs to see and was on the TAR as a second check. The facility's Skin Assessment Pressure Ulcer Prevention policy dated 04/06/25 documented the purpose of the policy was to systematically assess residents regarding risk of skin breakdown. Nursing was to accurately document observations and assessments of residents. Nursing was to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 123 residents. The sample included 24 residents, with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 45'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), and nasal oxygen tubing (medical device used to deliver supplemental oxygen therapy to individuals with low oxygen levels) were stored in a sanitary manner. This placed R45 at an increased risk for respiratory infection and complications.Findings included:- R45's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hallucination (sensing things while awake that appear to be real, but the mind created), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), obesity (due to excessive calories), sleep apnea (a disorder of sleep characterized by periods without respirations), hypertension (high blood pressure), muscle weakness, abnormalities of gait and mobility, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R45 had an impairment on both sides of her body and needed partial to moderate assistance with dressing and was dependent on staff for toileting. The MDS documented R45 needed to set up and clean up for eating and oral hygiene. The MDS documented R45 used a CPAP and continues oxygen use.R45's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 06/14/25 documented R45 was alert and oriented, had a BIMS score of 13. R45 had a new internal feeding and was trying to maintain her weight.R45's Care Plan dated 09/05/25 documented R45 would have no signs of poor oxygen absorption. Nursing staff were to monitor changes in the normal breathing pattern. The plan of care for R45 documented staff should report to nursing any difficulties R45 would have with using her CPAP.R45?s EMR under the Orders tab revealed the following physician orders:Three liters of oxygen per nasal canula can be weaned based on oxygen saturation reading, dated 04/15/25.Wash CPAP tubing and mask in the morning in warm, soapy water. Rinse and dry. Place in a large baggie after the CPAP was dried in the morning for sleep apnea, dated 05/22/25. Replace air filter as needed (PRN) for holes or blockage, dated 05/21/25.Assist with putting on CPAP at 12 midnight, make sure the water tub was filled to the line with distilled water. Make sure the mask was sealed at bedtime related to sleep apnea, dated 05/21/25.Replace the air filter on the CPAP at bedtime every 180 days, related to sleep apnea dated 06/01/25.On 07/21/25 at 08:33 AM, R45 laid in her bed. R45's CPAP laid on the bedside table, and R45's nasal oxygen tubing was placed on the handle of her oxygen cannister. R45's CPAP mask and nasal cannula were not stored in a sanitary manner.On 07/22/25 at 08:26 AM, R45's CPAP mask laid on her bedside table, and her nasal oxygen tubing was behind her bed on the bed frame. R45's nasal cannula and CPAP mask were not stored in a sanitary manner.On 07/23/25 at 12:48 PM, Certified Nurse's Aide (CNA) M stated she was not sure where the CPAP should be stored. She stated the nurses take care of the CPAP mask. CNA M stated that the oxygen nasal tubing should be placed in a bag when not in use.On 07/23/25 at 01:00 PM, Licensed Nurse (LN) G stated that the CPAP mask was washed after use and placed on a towel to dry; the mask should be covered. LNG stated when the mask was dry, the mask was placed in a sanitary bag for storage. LN G stated nasal oxygen tubing not in use was placed in a bag for storage. On 07/23/25 at 01:48 PM, Administrative Nurse D stated all respiratory equipment should be placed in a mesh bag when not in use.The facility's Oxygen Administration, Safety, Mask Types policy dated 07/28/24 documented that Oxygen administration is carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of oxygen would be on duty and is responsible for the proper administration of oxygen to the resident. Continuing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	education would be provided annually on safety, handling, and usage requirements for employees who handle medical gas (oxygen). Any employee that had the potential to handle oxygen must take the online course in the Success Center annually.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility identified a census of 123 residents. The sample included 24 residents, with six sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported when Resident (R) 54's hypotension (a medication that treats low blood pressure) medication Midodrine order lacked a diagnosis. The CP failed to identify and report when R54's Midodrine was administered by facility staff outside of the physician-ordered parameters. This placed R54 at risk of unnecessary medication administration and related complications. Findings included:- R54's Electronic Medical Record (EMR) documented diagnoses of orthostatic hypotension (blood pressure dropping with change of position), atrial fibrillation (rapid, irregular heartbeat), and syncope (fainting or passing out).?R54's Annual Minimum Data Set (MDS) dated 01/22/25 documented she had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R54 required setup to supervision assistance from staff. R54 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and an anticoagulant (a class of medications used to prevent the blood from clotting) medication regularly.R54's Functional Abilities Care Area Assessment (CAA) dated 01/23/25 documented she required minimal staff assistance with activities of daily living (ADL). R54's Care Plan, last revised on 04/24/25, directed staff to encourage the resident to get up slowly, sit on the side of the bed before standing. Staff were directed to apply compression stockings (specially made socks that fit tighter than normal that gently squeezed your legs and helped improve blood flow and reduce pain and swelling in your legs) as ordered. The Care Plan directed staff to monitor, document, and report to the health care provider as needed any signs and symptoms of hypotension.R54's Order Summary Report in the EMR documented a physician's order dated 04/24/25 for Midodrine hydrochloride (HCl) tablet 2.5 milligrams (mg) to give two tablets by mouth three times a day; hold if the systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than 120. This order lacked a diagnosis for use.A review of R54's Medication Administration Record (MAR) in the EMR for May 2025 revealed that R54's Midodrine was administered outside of the physician's ordered parameter on 10 of 93 opportunities.A review of R54's MAR in the EMR for June 2025 revealed that R54's Midodrine was administered outside of the physician's ordered parameter on three of 90 opportunities.A review of R54's MAR in the EMR for July 2025 revealed that R54's Midodrine was administered outside of the physician's ordered parameter on nine of 63 opportunities.A review of the CP's monthly Medication Reviews from May 2025 to July 2025 revealed the CP failed to identify and report that R54's Midodrine order lacked a diagnosis for use. The CP failed to identify and report when R54 was administered her Midodrine when her SBP was greater than 120.On 07/23/25 at 09:00 AM, Licensed Nurse (LN) I stated that the parameters should be followed when administering medications. R54 has a parameter to hold her Midodrine when her SBP is greater than 120.On 07/23/25 at 01:38 PM, Administrative Nurse D stated the physician ordered parameters should be followed when administering medications. Administrative Nurse D stated she expected the CP to identify and report any irregularities found. The facility's Medication: Drug Regimen Review policy dated 12/23/24 documented to ensure each medication order includes the date, route, dosage, frequency, strength, and reason for administration. The drug regimen review (DRR) would identify the following: Review of medications to assure that doses and duration are appropriate to each resident's clinical condition, age, and comorbidities; Monitoring of medications for efficacy and adverse consequences; Potential medication irregularities and response to these irregularities; Medication-related errors; and gradual dose reduction. The pharmacist would complete a written report noting any drug irregularities or issues of concern for each resident reviewed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. The facility identified a census of 123 residents. The sample included 24 residents, with six sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 54's hypotension (a medication that treats low blood pressure) medication order, Midodrine, included a diagnosis for use. The facility failed to ensure R54's physician-ordered parameter for Midodrine was followed before the medication was administered. This placed R54 at risk of unnecessary medication administration and related complications. Findings included:- R54's Electronic Medical Record (EMR) documented diagnoses of orthostatic hypotension (blood pressure dropping with change of position), atrial fibrillation (rapid, irregular heartbeat), and syncope (fainting or passing out).?R54's Annual Minimum Data Set (MDS) dated 01/22/25 documented she had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R54 required setup to supervision assistance from staff. R54 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and an anticoagulant (a class of medications used to prevent the blood from clotting) medication regularly.R54's Functional Abilities Care Area Assessment (CAA) dated 01/23/25 documented she required minimal staff assistance with activities of daily living (ADL). R54's Care Plan, last revised on 04/24/25, directed staff to encourage the resident to get up slowly, sit on the side of the bed before standing. Staff were directed to apply compression stockings (specially made socks that fit tighter than normal that gently squeeze your legs and helped improve blood flow and reduce pain and swelling in your legs) as ordered. The Care Plan directed staff to monitor, document, and report to the health care provider as needed any signs and symptoms of hypotension.R54's Order Summary Report in the EMR documented a physician's order dated 04/24/25 for Midodrine hydrochloride (HCl) tablet 2.5 milligrams (mg) to give two tablets by mouth three times a day; hold if the systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than 120. This order lacked a diagnosis for use.A review of R54's Medication Administration Record (MAR) in the EMR for May 2025 revealed that R54's Midodrine was administered outside of the physician's ordered parameter on 10 of 93 opportunities.A review of R54's MAR in the EMR for June 2025 revealed that R54's Midodrine was administered outside of the physician's ordered parameter on three of 90 opportunities.A review of R54's MAR in the EMR for July 2025 revealed that R54's Midodrine was administered outside of the physician's ordered parameter on nine of 63 opportunities.On 07/23/25 at 09:00 AM, Licensed Nurse (LN) I stated that the parameters should be followed when administering medications. R54 has a parameter to hold her Midodrine when her SBP was greater than 120.On 07/23/25 at 01:38 PM, Administrative Nurse D stated the physician-ordered parameters should be followed when administering medications. The facility's Medication: Unnecessary-R/S, LTC policy dated 10/15/24 documented each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: In excessive dose (including duplicate therapy); For excessive duration; Without adequate monitoring; Without adequate indications for its use; In the presence of adverse consequences which indicate the dose should be reduced or discontinued; Any combination of the reasons above.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility identified a census of 123 residents. The sample included 24 residents, with five reviewed for nutritious diets. Based on observation, record review, and interviews, the facility failed to ensure meals were served at a palatable, safe, and appetizing temperature for Residents (R) 80 and R104. This deficient practice placed the residents at risk for risks related to impaired nutrition and weight loss.Findings included:- On 07/21/24 at 07:00 AM, a walkthrough of the facility's secured 100 Hall was completed. An inspection of the unit's kitchenette revealed that the kitchen had an oven, and a microwave included in the kitchenette. The microwave had signage that noted When heating foods in the microwave, please make use of the thermometers provided to ensure that your food reaches the safe temperature of 165 degrees. An inspection of the cabinet to the right of the microwave revealed a thermometer and a box of disposable thermometer covers. An inspection of the refrigerator revealed uncovered and labeled food plates from the previous evening's dinner on the top two shelves. The refrigerator had food residue on the inside of the walls. On 07/22/25 at 07:30 AM, Certified Nurse Aide (CNA) N assisted the kitchen staff with serving food during breakfast. CNA N received a plate for R80 from the portable serving station. CNA N carried the plate over to the microwave and put the food plate in it, and cooked it for one minute. CNAN then brought the plate back to the portable serving station, placed syrup on the pancakes, and gave the food plate to R80 at the table. The food temperature was never checked after being microwaved and served to ensure a safe temperature. On 07/22/25 at 07:54 AM, CNA N labeled and placed breakfast plates for R2, R71, R102, and R104 directly in the refrigerator briefly without covers and closed the refrigerator. CNA N then asked the kitchen staff to retrieve four dome covers for the plates placed in the refrigerator. The plates were covered within five minutes. On 07/22/25 at 09:13 AM, R104 was escorted to the dining area by staff. CNA N retrieved R104's breakfast plate from the refrigerator and placed it in the microwave for one minute and thirty seconds. CNA N delivered R104's breakfast plate to her at the dining room table next to the juice machine. The food temperature was never checked after being microwaved and served to ensure a safe temperature. On 07/23/25 at 12:49 PM, CNA M stated food should always be placed in the fridge with a cover or plastic barrier to prevent contamination. She stated that staff were expected to check the temperature of food after microwaving. She stated each kitchenette had thermometers available. On 07/23/25 at 01:03 PM, Licensed Nurse G stated that staff were expected to use the microwaves to warm up food sometimes. She stated that each kitchen had thermometers to ensure the food was heated to safe temperatures. On 07/23/25 at 01:40 PM, Administrative Nurse D stated staff were expected to use the thermometers each time food was heated in the microwave ovens. The facility's Texture- Modified Diets- Food and Nutrition Services policy, revised 05/2025, indicated residents will receive food that is nourishing, attractive, and palatable. The policy indicated that resident meals would maintain the appropriate texture, consistency, and safe serving temperatures.

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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. The facility identified a census of 123 residents. The sample included 24 residents, with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to update Resident (R) 49's plan of care to reflect the services, medication, and equipment provided to R49 by hospice. This deficient practice created a risk for missed opportunities for services and delayed physical, mental, and psychosocial needs for R49. Findings included:- R49's electronic medical record (EMR) documented diagnoses of Atherosclerotic heart disease of native coronary artery (plaque buildup in and on the walls of the heart arteries) 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). The admission Minimum Data Set (MDS) dated 06/25/25 documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. The MDS documented R49 required partial to moderate assistance for showers or bathing, and dressing. The MDS documented R49 was independent for moving from seated to lying position, lying to sitting on side of the bed, sit to stand, and transfers from chair or bed.R49's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/25/25, documented R49 had scored a nine on his BIMS, had a diagnosis of heart disease, hemiplegia (paralysis on one side of the body), and hemiparesis (weakness on one side of the body) following cerebral infarction. The CAA documented R49 received Hospice services.R49's Care Plan, dated 06/19/25, documented R49 had a terminal prognosis and was being followed by hospice. An intervention dated 06/19/25 documented a consult with a health care provider and Social Services to have Hospice care for the resident in the facility. An intervention dated 06/19/25 documented reviewing the resident's advanced care planning choices and assisting others to respect choices. An intervention dated 06/19/25 documented staff were to encourage R49 to express feelings. An intervention dated 06/19/25 documented the adjustment of the provision of Activities of Daily Living (ADL) to compensate for the resident's changing abilities and encourage participation to the extent the resident wishes to participate. An intervention dated 06/19/25 documented managing restlessness through environmental manipulation or pharmacological intervention and using the least sedating pharmacological means possible to control restlessness. An Intervention with an initiated date of 06/19/25 documented R49 required the assistance of one Certified Nurse Aide (CNA) for bathing, and to assist with shaving, and nail care as needed. The Intervention further documented that hospice also assisted with bathing.R49's Care Plan lacked documentation related to which days baths were provided by hospice. R49's Care Plan lacked documentation related to any medications, medical equipment, or supplies provided by hospice.The Hospice Plan of Care provided by hospice for R49 documented the following under the Durable Medical Equipment (DME) and supplies section, which included a shower chair, walker, wheelchair, wheelchair cushion, barrier cream, bed pads, briefs, gloves, underwear (pull-ups), urinal, wash basin, and wipes.R49?s EMR under the Orders tab revealed the following physician order: Admit to hospice with diagnosis of Atherosclerotic heart disease of native coronary artery. The order was dated 06/20/25.An observation on 07/22/25 at 08:47 AM revealed R49 rested on his bed in his room.On 07/23/25 at 12:48 PM, CNA M stated that CNAs can review the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) to find out what services hospice provides for the residents, or they can review the hospice book. CNA M stated that hospice visits and bathing days will usually be listed on the Kardex. CNA M stated that staff were to complete baths on the opposite days that hospice provides them.On 07/23/25 at 01:03 PM, Licensed Nurse (LN) G stated that staff can check the resident's profile on the EMR to find out who is on hospice and the phone number of the hospice company. LN G stated the hospice books show resident shower days, and the hospice aides have assigned shower days when they come out. LN G stated nurse visitation varies unless the resident was actively dying. LN G stated she believed the nurses charted in the hospice book when (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they came to the facility. LN G stated the facility provides showers on the opposite days that hospice provides them. She stated that information should be on the care plan. LN G further stated that the care plan for the facility and the care plan hospice provides should align and show what supplies, services, and equipment were provided.On 07/23/25 at 01:38 PM, Administrative Nurse D stated the facility's care plan should line up with the care plan hospice provides. Administrative Nurse D stated that staff and hospice staff should document when bathing was done. Administrative Nurse D stated she was unsure if things such as wheelchairs, pads, briefs, or other supplies provided by hospice should be on the facility's care plan. Administrative Nurse D stated she wasn't sure if that information was only kept in the hospice binders or if it should have been on the facility care plan as well.The facility's undated Delineation of Nursing and Aide Services policy documented facility responsibilities to oversee the provision of room and board services as indicated by the patient's level of care, including coordination with hospice staff in implementation and update of the joint plan of care.