

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: 175267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2026
NAME OF PROVIDER OR SUPPLIER Shawnee Gardens Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6416 Long Street Shawnee, KS 66216	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to the residents of the facility appropriately to prevent the potential for food borne bacteria in one of the kitchens. Findings included:- During an initial tour of the kitchen on 08/03/2026 at 07:42 AM, the following areas of concern were noted: 1. One three-tiered black plastic cart used for food preparation had two melted areas on the second tier. 2. A black wire rack in the refrigerator walk-in had a build-up of food debris. 3. A wire rack holding clean pots and pans had multiple areas of rust. 4. Thirty-five plastic trays, used for serving residents meals, were put away wet. 5. A large plastic container holding dry rice lacked a lid. 6. A plastic container of uncooked oatmeal was left uncovered. During an initial tour of two kitchenettes on 08/03/2026 at 08:00 AM, the following area of concern was noted: 1. The microwave in each location had a build-up of dried food on all inside surfaces of the microwaves. On 08/05/2026 at 07:56 AM, Dietary Staff BB confirmed the listed areas of concern. The facility policy, Sanitation of Dining and Food Service Areas, dated 2020, included: The Dining Services staff will uphold sanitation of the dining areas according to a thorough, written schedule.		

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly by failing to ensure the lid of the dumpster was kept closed and failing to ensure the trash bags filled with dietary and nursing trash were kept in an enclosure. Findings included:- During an initial tour of the kitchen on 08/03/2026 at 07:42, the following concerns were identified: 1. One of two dumpsters had the cover open. There were random pieces of trash littering the ground around the dumpster. 2. On 08/05/2026 at 07:45 AM, two of the two dumpsters were empty. There were 14 bags of trash containing dietary and nursing trash stacked next to one of the empty dumpsters. On 08/05/2026 at 07:56 AM, Administrative Staff A stated the sanitation company had not picked up the garbage on 08/04/2026, as planned but had picked up the garbage in the early morning of 08/05/2026. Administrative Staff A confirmed the bags of garbage had not been placed into the empty dumpsters and were stacked on the ground next to the dumpster. The facility policy for Garbage and Rubbish Disposal, dated 2020, included: Garbage and rubbish will be disposed of to ensure a clean and sanitary kitchen that does not encourage insects or rodents. All outside dumpsters will be maintained in clean and sanitary condition.		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and interview, the facility failed to ensure the staff person designated as the Infection Preventionist (IP), who was responsible for the facility's Infection Prevention and Control Program (IPCP), was certified and had completed the specialized training in infection prevention and control Findings included:- On 08/04/2026 at 08:45 AM, Administrative Nurse D, upon request, was unable to provide evidence of certification for the facility's IP. On 08/04/2026 at 08:57 AM, Administrative Nurse D stated that she took over the IP position in December 2025 and that she had acquired her IP certification at another facility and did not have a copy of it. She stated that she had been unable to obtain it. The facility's policy Infection Preventionist, dated 07/07/2026, documented the facility would employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program. The facility would designate a qualified individual as Infection Preventionist (IP) whose primary role was to coordinate and to be actively accountable for the facility's infection prevention and control program, including the antibiotic stewardship program. The IP must have obtained specialized IP certification beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate of completion or equivalent documentation.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on record review, observation, and interviews, the facility failed to ensure a safe, clean, home-like environment in the facility extended recovery unit (ERU) lounge area. Findings include:- Observed on 08/03/2026 at 07:47 AM, the ERU lounge area, across the hall from the shower room and by the exit to the smoking area, had three paper towels on the floor next to the sink, and the faucet was turned on. There was an empty medicine cup on the floor. There was an empty cup, unfolded gait belt, and a clock that had a loose battery on it, sitting on the table that was under the television. There was food debris on the floor next to a recliner, no trash bag in the trash can, and a dirty cup laid upside down on the counter next to the sink, the ice machine had a visible substance on it, and there was brown debris on the drain tray. There were two plastic cups stacked together with a visibly dirty coffee cup sitting next to the ice machine on the counter. The counter, under the ice machine, was visibly dirty with white debris. There was an unfolded gait belt on the table under the television and a clock with the battery laying on it on the table. Observed on 08/03/2026 at 02:34 PM, the ERU lounge area had a dirty coffee cup and dirty plastic cup sitting next to the ice dispenser machine on the counter. Observed on 08/04/2026 at 07:55 AM, the ERU lounge area had an empty medicine cup on the floor in front of the sink next to the trash can along with a wrapper and a piece of paper towel sitting on the floor. There was a dirty cup sitting on the table under the television and the ice machine was visibly dirty and a dirty cup sat next to sink on the counter. On 08/05/2026 at 09:32 AM, Certified Nurse Aide (CNA) P stated that she did not know who was responsible for cleaning the ERU lounge area and ice machine. On 08/05/2026 at 09:36 AM, Licensed Nurse (LN) H stated that there was a third-party contractor that cleaned the ice machine in the ERU lounge area and staff were to pick up the trash and dishes. On 08/05/2026 12:36 PM, Administrative Nurse D stated that a third-party contractor came semiannually and cleaned the ice machine in the ERU lounge area. She stated that she had discussed with staff that they were to check the ERU lounge area for trash and debris. The facility policy Safe and Homelike Environment, dated 07/15/2026, documented in accordance with residents' rights, the facility would provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.		

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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. Based on observation, record review, and interviews, the facility failed to ensure an environment free from accident hazards when staff failed to secure disinfectant chemicals in a locked area and out of the reach of the 10 cognitively impaired, independently mobile residents. Findings included:- During the initial tour of the facility's Memory Unit on 08/03/2026 at 08:10 AM, an unlocked cabinet over the dining counter had an unmarked bottle with brown liquid, a bottle of rapid cleaner disinfectant, and two small bottles of peri care wash. On 08/03/2026 at 08:00 AM, Certified Medication Aide (CMA) stated chemicals should be locked, and it was every staff's responsibility to ensure chemicals were in a locked cabinet. On 08/03/2026 at 08:10 AM, Licensed Nurse (LN) G stated that chemicals should be locked in a cabinet, or placed in the dirty laundry room, which was locked. On 08/05/2026 at 12:33 PM, Administrative Nurse D stated chemicals should be in a locked cabinet, or behind a locked door. She stated all bottles should be labeled with contents. The facility's Accidents and Supervision policy documented the resident's environment would remain as free of accident hazards as possible. Each resident would receive adequate supervision and assistive devices to prevent accidents.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete comprehensive Minimum Data Set Assessment (MDS) for two Residents (R)67, regarding discharge and R10, regarding nutrition. Findings included:- 1. R67's Electronic Medical Record (EMR) recorded a Significant Change Minimum Data Set (MDS), dated [DATE], with the Activity Care Area Assessment (CAA), dated 06/05/26, triggered but lacked an analysis of findings.2. R10's EMR recorded a Significant Change Minimum Data Set (MDS) dated 05/01/2026, with the Nutritional Status CAA dated 05/06/2026 triggered but lacked analysis of findings.On 08/05/26 at 11:15 AM, Administrative Nurse D confirmed the activity CAA on the significant change MDS for R67, triggered but lacked an analysis of findings.On 08/04/26 at 11:30 AM, Administrative Nurse E stated it was the expectation for triggered CAAs to include an analysis of findings. Administrative Nurse E confirmed the Nutritional Status CAA on Significant change MDS dated [DATE] lacked analysis.The facility policy for MDS, revised 09/29/25, included: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary (ID) care plan.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for two residents: Resident (R)118, regarding discharge location, and R10, regarding the use of continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). Findings included:- 1. R118's Electronic Medical Record (EMR) recorded an MDS dated [DATE], which recorded R118 discharged , with return anticipated, to Home/Community, on 07/13/2026.R118's EMR under the Prog Notes tab, 07/13/2026, documented R118 admitted to the hospital.2. R10's EMR recorded a Significant Change MDS dated 05/01/2026, which lacked documentation of the use of a CPAP during the observation period.R10's EMR under the Orders tab revealed the following physician orders: Non-invasive ventilator (NIV) settings: Intelligent Volume-Assured Pressure Support with Auto EPAP (iVAPS-AE), maximum 25 centimeter (cm), minimum EPAP 5 cm, maximum expiratory positive airway pressure (EPAP) 15 cm, minimum pressure support (PS) 5 cm, maximum PS 15 cm, Vt 500 milliliter (ml), rate-auto dated 03/06/2026.On 08/04/26 at 11:30 AM, Administrative Nurse E stated the MDS dated [DATE], for R118 was inaccurate as R118 discharged from the facility to the hospital and did not discharge to her Home or the Community. Administrative Nurse E stated it was the expectation for the MDS to be completed accurately. Administrative Nurse E stated R10's CPAP should have been marked yes related to his usage of the CPAP in the facility.The facility policy for MDS, revised 09/29/25, included: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary (ID) care plan.		

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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. Based on observation, interview, and record review, the facility failed to provide the necessary activities of daily living (ADL) services for Resident (R)8, who did not receive adequate assistance with personal hygiene. Findings included:- Review of the Electronic Health Record (EHR) revealed R8's diagnoses included subarachnoid hemorrhage (bleeding in the space just outside of the brain), lack of coordination, contracture of muscle of multiple sites to lower body (abnormal permanent fixation of a joint or muscle), quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and dementia (a progressive mental disorder characterized by failing memory and confusion).R8's Annual Minimum Data Set (MDS), dated 10/13/2025, documented a Brief Interview for Mental Status (BIMS) score of eight indicating moderate cognitive impairment. He required a wheelchair for mobility; he required set-up/clean-up assistance for eating and was dependent on staff for bathing and all other ADLs.The Functional Abilities Care Area Assessment (CAA), dated 10/13/2025, documented R8 was dependent on staff for transfers to the shower and with personal hygiene.The Urinary Incontinence and Indwelling Catheter CAA, dated 10/13/2025, noted that R8 was dependent on staff for toileting hygiene and was incontinent of urine.R8's Quarterly MDS, dated 07/15/2026, documented a BIMS score of three indicating severe cognitive impairment. He required a wheelchair for mobility; he required set-up/clean-up assistance for eating and was dependent on staff for bathing and all other ADLs.R8's Care Plan dated 10/18/2023, instructed staff to provide substantial maximal assistance with oral hygiene, supervision with set-up assistance for eating, and he was dependent on staff for toileting hygiene, upper body dressing and to shower/bathe. Staff was instructed to provide R8, who was dependent on staff to shower and bathe, with washcloths and soapy water for sponge bathing if bathing was refused.R8's EHR, under the bathing Tasks showed R8 received bathing eight times between 07/06/2026 and 08/04/2026. There were three documented bathing refusals in July 2026. The task did not show if the task performed was a bath, a shower or a bed bath.R8's EHR lacked documentation that R8 had refused to have his hair washed, face cleaned or clothes changed during the survey and observation dates below.Observation on 08/03/2026 at 09:22 AM, revealed R8 sat in his wheelchair at a table in the dining room. R8's hair was disheveled and uncombed. The hair looked greasy and had various sized pieces of debris throughout his shoulder length hair. R8 had a beard and mustache from his upper lip to just below his chin that had small to medium pieces of debris throughout his beard and small crumbly material around his mouth and lips.Observation on 08/04/2026 at 07:51 AM, revealed R8 sat at a table in the dining room eating his breakfast. His shirt had dried food stains to the right sleeve of his shirt that were reddish in color. His hair had large pieces of white debris and flakes throughout his hair. His hair looked greasy, disheveled, and uncombed.Observation on 08/04/2026 at 01:20 PM, revealed R8 was in his room in a wheelchair receiving wound care from Licensed Nurse H. R8's pants were wet in the front groin-area. His hair looked unkempt, matted, uncombed, oily and greasy.Observation on 08/05/2026 at 08:23 AM, revealed R8 was in his bed watching television. A tray with his morning meal was on table at bedside. His hair looked unkempt, disheveled, oily, and he had small to medium white debris throughout his hair,On 08/04/2026 at 08:42 AM, R8 reported that he had only been allowed one shower since admission and was told by staff he would get a shower two weeks ago but never did. He stated that he had requested showers but did not get them and said he had to give himself bed baths.On 08/05/2026 at 10:43 AM, Certified Nurse Aide (CNA) O reported that R8 does not go into the shower. CNA O said (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff gives R8 a bed bath, and during his bed bath staff used washcloths with some soap on them for his hair. On 08/05/2026 at 10:49 AM, Licensed Nurse (LN) H reported that he was unsure if staff cleaned R8's hair well when he was bathed. LN H reported R8 only received a shower 25% of the time and received a bed bath the other 75% of the time. LN H stated R8 was dependent on staff to transfer him to the shower with a mechanical lift which made it difficult when staff transferred him to the shower chair. On 08/05/2025 at 01:30 PM, Administrative Nurse D stated that R8 was dependent on staff and needed to be transferred using a mechanical lift. Administrative Nurse D stated it was her expectation that R8 received a bed bath, staff should use the available shower caps that were designed to wash/shampoo hair. Administrative Nurse D stated staff would be educated on how the shower caps were to be used and would use them going forward. The facility policy Activities of Daily Living dated 12/01/2025, documented that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide an ongoing program of activities designed to meet the interests and well-being of Resident (R)11 and R67. Findings included:- 1. R11's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R11's Significant Change Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. R11's preferences for activities included listening to music, being around animals such as pets, spending time outdoors, and participating in her favorite activities. She was dependent on staff for locomotion on the unit in her wheelchair. R11's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 04/01/2026, documented staff should ask her yes/no questions. R11's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. She was dependent on staff for locomotion on the unit in her wheelchair. R11's Care Plan for activities, revised 07/02/2026, instructed staff the resident enjoyed listening to music, watching movies, visiting with her family, and resting in her recliner. On 08/03/2026 at 08:37 AM, R11 sat in her specialized wheelchair at the dining table with peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 07:16 AM, R11 sat in her specialized wheelchair at the dining table with peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 09:59 AM, R11 sat in her specialized wheelchair at the dining table with peers. There was no activity or stimulation occurring at that time. R11 called out to several staff on several occasions with no response. On 08/04/2026 at 12:22 PM, Certified Nurse Aide (CNA) M stated the resident did not participate in activities because she had dementia. On 08/04/2026 at 12:24 PM, CNA N stated R11 could not participate in activities due to her cognition; the resident would sit and people watch. On 08/04/2026 at 01:12 PM, Activity Staff Z stated there were multiple activities for residents with cognitive loss to do while they sat at the dining room table. Activity Staff Z stated she would need to do education with staff to ensure the activities were brought out and used on a routine basis. On 08/05/2026 at 10:00 AM, Licensed Nurse (LN) I stated the resident rarely participated in activities due to her cognitive loss. 2. R67's EMR documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R67's Significant Change MDS dated 06/05/2026, documented the staff assessment for cognition revealed severe cognitive impairment. R67's preferences for activities included listening to music, being around animals such as pets, spending time outdoors, and participating in her favorite activities. She was dependent on staff for locomotion in her wheelchair. R67's Activity CAA dated 06/05/2026, triggered but lacked an analysis of findings. R67's Cognitive Loss/Dementia CAA, dated 06/05/2026, documented R67 had dementia. R67's Care Plan for activities, revised 06/18/2026, instructed staff it was important for her to have the opportunity to engage in daily routines and activities. She enjoyed visiting with her family, going outdoors, and looking out the window. On 08/03/2026 at 08:37 AM, R67 sat in her wheelchair at the dining table with her peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 07:16 AM, R67 sat in her wheelchair at the dining table with her peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 09:59 AM, R67 sat in her wheelchair at the dining table with her peers. There was no activity or stimulation occurring at that time. On 08/04/2026 at 12:22 PM, Certified Nurse Aide (CNA) M stated the resident did not participate in activities because she had dementia. On 08/04/2026 at 12:24 PM, CNA N stated R67 could not participate in activities due to her cognition. The resident would sit and people watch. On 08/04/2026 (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 01:12 PM, Activity Staff Z stated there were multiple activities for residents with cognitive loss to do while they sat at the dining room table. Activity Staff Z stated she would need to do education with staff to ensure the activities were brought out and used on a routine basis. On 08/05/2026 at 10:00 AM, Licensed Nurse (LN) I stated the resident rarely participated in activities due to her cognitive loss. On 08/05/2026 at 12:33 PM, Administrative Nurse D stated it was the expectation for the residents with cognitive loss to have activities they enjoy. The facility policy for Activities, revised 01/07/26, included: It is the policy of the facility to provide an ongoing program to support residents in their choice of activities.		

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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** Based on observation, interview, and record review, the facility failed to ensure appropriate wheelchair positioning for Resident (R)11. Findings included:- R11's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R11's Significant Change Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. She had limited range of motion (ROM) in her bilateral lower extremities (LE-legs). R11 was dependent on staff for locomotion in her wheelchair. R11's Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 04/01/2026, did not trigger. R11's Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed severe cognitive impairment. She had limited ROM in her bilateral LEs and was dependent on staff for locomotion in her wheelchair. R11's Care Plan, revised 07/02/2026, instructed staff she was dependent on staff for locomotion in her wheelchair. On 08/03/2026 at 08:37 AM, R11 sat in her wheelchair at the dining room table. Her feet hovered several inches above the footrest of the wheelchair. On 08/04/2026 at 07:16 AM, R11 sat in her wheelchair at the dining room table. Her feet hovered several inches above the footrest of the wheelchair. On 08/04/2026 at 09:59 AM, R11 continued to sit in her wheelchair at the dining table with her feet hovering several inches above the footrest of the wheelchair. On 08/04/2026 at 12:22 PM, Certified Nurse Aide (CNA) M confirmed R11's feet did not reach the footrests of her wheelchair. On 08/04/2026 at 12:24 PM, CNA N stated R11's feet did not reach the footrests of the wheelchair. CNA N stated the footrest of the wheelchair needed to be adjusted to fit R11 better. On 08/05/2026 at 12:33 PM, Administrative Nurse D stated R11's footrest needed to be adjusted to better fit the resident and support her feet. The facility policy for Use of Assistive Devices, revised 01/27/2026, included: The use of assistive devices will be based on the resident's needs, as indicated.		

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NAME OF PROVIDER OR SUPPLIER Shawnee Gardens Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6416 Long Street Shawnee, KS 66216	
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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. Based on interviews, observation, and record review, the facility failed to ensure Resident (R) 10's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask and oxygen tubing was stored in a sanitary manner to prevent contamination and respiratory infections. Findings included:- R10'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), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dependent on dialysis (a procedure where impurities or wastes are removed from the blood), dependent on supplemental oxygen.The Significant Change Minimum Data Set (MDS) dated 05/01/2026 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS lacked documentation R10 was provided with his CPAP during the observation period. R10's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 05/06/2026, documented staff would assist R10 with activities of daily living (ADLs) as needed and encourage his participation with ADLs.R10's Care Plan documented the following interventions:04/24/2026 - Staff would change oxygen tubing and rinse oxygen concentrator filter weekly. Staff would check oxygen saturation as ordered, see the treatment administration record. Staff would monitor changes in oxygenation status and keep the physician informed. Staff would administer R10's oxygen as ordered, see the treatment administration record. R10's EMR under the Orders tab revealed the following physician orders:Non-invasive ventilator (NIV) settings: Intelligent Volume-Assured Pressure Support with Auto EPAP (iVAPS-AE), maximum 25 centimeters (cm), minimum EPAP 5 cm, maximum expiratory positive airway pressure (EPAP) 15 cm, minimum pressure support (PS) 5 cm, maximum PS 15 cm, Vt 500 milliliter (ml), rate-auto dated 03/06/2026.Oxygen 3 liters per minute (LPM) continuous to keep oxygen saturation greater (>) than 90%, every shift for chronic respiratory failure dated 03/06/2026.Assist R10 with putting on NIV mask every night (Turn on machine, put mask on, and hit Start button on screen). Wake him to put on mask, even if he was already asleep. Make sure oxygen is set at 3LPM and connected to the NIV dated 03/06/2026.Assist R10 with taking the NIV mask off in AM (Take off mask and press and hold power button to turn off machine). Make sure to put oxygen on at 3LPM via nasal cannula, for obstructive sleep apnea (OSA) dated 03/06/2026.On 08/03/2026 at 09:45 AM, R10's NIV mask lay directly on the bedside table next to the machine, not in a container. On 08/04/2026 at 07:42 AM, R10 lay asleep on his bed with lights turned off. The head of his bed was elevated, and his oxygen was on. On 08/05/2026 at 10:26 AM, R10's oxygen tubing was wrapped together and placed under the handle of the oxygen concentrated machine, not in a container.On 08/05/2026 at 10:20 AM PM, Certified Nurse Aide (CNA) MM stated she would transfer the oxygen tubing from the concentrator to the portable oxygen tank after getting R10 up for the day. CNA MM stated she would then place the oxygen tubing inside the concentrator handle. On 08/05/2026 at 10:26 AM, Licensed Nurse (LN) I stated R10's CPAP mask and oxygen tubing should be stored in a bag when not in use.On 08/05/2016 at 12:30 PM, Administrative Nurse D stated she expected R10's respiratory equipment to be cleaned and changed as ordered. Administrative Nurse D stated she expected the respiratory equipment stored in the bag that was dated.The facility's Oxygen Administration policy dated 05/21/2026 documented oxygen was administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review, and interviews, the facility failed to complete and document a post hemodialysis (a procedure where impurities or wastes are removed from the blood) assessment for Resident (R) 10. Findings included:- R10'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), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dependent on dialysis (a procedure where impurities or wastes are removed from the blood), dependent on supplemental oxygen.The Significant Change Minimum Data Set (MDS) dated 05/01/2026 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R10 had received dialysis during the observation period. R10's Nutritional Status Care Area Assessment (CAA), dated 05/06/2026 lacked analysis. R10's Care Plan, documented the following interventions: 02/26/2026 - Staff would encourage R10 to go to scheduled dialysis appointments.R10's dialysis days were on Monday, Wednesday, and Friday at 11:30 AM. Staff would send a snack meal with R10 if at dialysis during a meal. Staff would monitor his shunt site for signs and symptoms of infection, bleeding, or edema.Staff would not take blood pressure in the arm that has a shunt.Staff would obtain dry weights prior to dialysis treatment. Staff would weigh daily and notify physician if gain or loss (blank) in one day or (blank) gain or loss in a week. (Specify).TR10's EMR under the Orders tab revealed the following physician orders:Dialysis on Monday, Wednesday, and Friday. Have R10 ready by 10:30 AM for dialysis dated 03/18/2026. The physician order lacked location of the dialysis provider.Monitor arteriovenous (AV) fistula/graft site for signs or symptoms of infection, edema, and bleeding upon return from dialysis. Notify physician if any signs noted. If site has bleeding, apply pressure for 15 minutes and notify physician if bleeding does not stop every shift. Port site right upper chest dated 03/07/2026.Weigh every Monday, Wednesday, and Friday prior to dialysis for fluid management for dialysis dated 03/06/2026. Review of the Dialysis Communication Form provided by the facility from 05/01/2026 to 08/03/2026 revealed 41 dialysis communication sheets. No post dialysis documentation was completed on the following 25 dates 05/01/2026, 05/08/2026, 05/11/2026, 05/13/2026, 05/18/2026, 05/2026, 05/22/2026, 05/27/2027/2026, 05/29/2026, 06/01/2026, 06/2026, 06/2026, 06/15/2026, 06/17/2026, 07/01/2026, 07/03/2026, 07/06/2026, 07/17/2026, 07/20/2026, 07/22/25026, 07/24/2026, 07/27/2026, 07/31/2026, and 08/03/2026.On 08/04/2026 at 07:42 AM, R10 laid asleep on his bed with lights turned off. The head of his bed was elevated, and his oxygen was on. On 08/05/2026 at 10:20 AM, Certified Nurse Aide (CNA) MM stated she would assist R10 with dressing and obtain his vital signs and weight before leaving for dialysis.On 08/05/2026 at 10:26 AM, Licensed Nurse (LN) I stated he would obtain R10's vital signs prior to leaving for dialysis. LN I stated the dialysis communication book was sent along with R10 to dialysis. LN I stated R10 would be assessed upon his return from dialysis and it would be documented on the dialysis communication sheet.On 08/05/2016 at 12:30 PM, Administrative Nurse D stated she expected the charge nurse to complete an assessment for R10 post return from his dialysis appointment. Administrative Nurse D stated she expected the nurse to document the assessment on the dialysis communication sheet. The facility's Hemodialysis policy dated 11/25/2025 documented the facility would provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis.		

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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. Based on interviews, observation, and record review, the facility failed to ensure collaboration with the hospice provider for Resident (R) 2. Findings included:- R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), dementia (a progressive mental disorder characterized by failing memory and confusion), and myasthenia gravis (an abnormal condition that causes muscles to tire and weaken easily).The Quarterly Minimum Data Set (MDS) dated 05/27/2026 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R2 had received hospice services during the observation R2's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 02/27/2026 documented staff would assist her with activities of daily living as needed. R2 would work with therapy services to assist in increasing her functional mobility.R2's Care Plan documented the following interventions: 02/16/2026- Staff would assess her pain, restlessness, agitation, constipation, and other symptoms of discomfort.Staff would administer medication as ordered and evaluate effectiveness.Staff would provide nonpharmacological approaches to aid in decreasing discomfort.Staff would notify hospice of significant changes, clinical complications needing plan of care change, need to transfer to emergency department or death. Staff would provide medications per hospice and physician orders, see medication administration record and treatment administration record. Staff would provide food and fluids as desired for physical and emotional comfort.The plan lacked the frequency of hospice staff visits and the care they would provide, as well as the medications and equipment to be provided by hospice.R2's EMR under the Orders tab revealed the following physician orders:Admit to hospice with a diagnosis of myasthenia gravis dated 02/13/2026.On 08/04/2026 at 07:45 AM, R2 sat in a wheelchair in her room and had self-propelled herself to the bathroom.On 08/05/2026 at 10:20 AM PM, Certified Nurse Aide (CNA) MM stated she was informed of which resident received hospice services from the nurse during report. CNA MM stated the information for the services provided by hospice was listed on the residents' personalized care plan. On 08/05/2026 at 10:26 AM, Licensed Nurse (LN) I stated he communicated with hospice staff when they came to the facility to provide care. LN I stated the information of what services are provided by hospice should be listed on the resident's care plan.On 08/05/2016 at 12:30 PM, Administrative Nurse D stated she expected there to be collaboration of care and services provided by hospice and that collaboration should be listed on the resident's care plan.The facility's Coordination of Hospice Services policy dated 12/02/2025 documented when a resident chose to receive hospice care and services, the facility would coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record reviews and interviews, the facility failed to post the required staffing information when the posted nurse staffing sheet did not list the actual staff hours worked as required. Findings included:- Review of the posted staffing sheets from 02/02/2025 to 08/02/2026 revealed the facility was unable to provide the posted staffing documentation that contained all the actual hours worked. The sheets contained the number of staff and the scheduled hours but not the actual hours worked. On 08/05/2025 at 12:33 PM, Administrative Staff A stated the staff coordinator was the person who posted and filled out the forms daily. She stated Administrative Staff A created a posted staffing sheet specifically to ensure all required information was posted. On 08/05/2026 at 12:55 PM, Administrative Staff A stated he had designed a posted staffing sheet to ensure the sheet that was posted met all required criteria for the state. He stated he did have a lot of the actual staff hours worked, but they were not posted. Administrative Staff A stated on the log staff must sign their hours. He confirmed the log was in a binder in the lobby, but it was not posted. The facility's Nurse Staffing Posting Information Policy last revised on 02/02/2025 documented it was the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The information posted would be presented in a clear and readable format. The posted staffing would be placed in a prominent place readily accessible to residents, staff, and visitors.		