STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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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. 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.Findings included: - During an initial tour of the kitchen on 04/27/26 at 08:57 AM, the following areas of concern were noted:The three-door reach-in freezer contained food debris on the bottom shelf.The three-door reach-in refrigerator had an unknown spilled liquid on the bottom shelf.The drain to the ice machine lacked a two-inch air gap.Two black two-tiered plastic carts, used to store clean dishes, had food debris on the bottom tier.The bottom shelf of the steamtable, used to store plate covers, had a build-up of food debris.On 04/28/26 at 01:57 PM, Dietary Staff BB confirmed the noted areas were in need of cleaning. The facility did not have a cleaning schedule or a policy regarding kitchen cleanliness.

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and staff interview, the facility failed to ensure comprehensive assessments were fully completed when staff failed to complete Care Area Assessments (CAA) that addressed the individual underlying causes, contributing factors and risk factors for Resident (R) 1, R2, R3, R4, R5, R7, R9, R10, R12, R15, R22, R28, R61, R71 R91, R98.Findings included:- R1's Electronic Health Record (EHR) recorded an Annual Minimum Data Set (MDS), dated [DATE], which trigged the Mood/Behavior, Functional Abilities/ Dementia/Cognition Loss the CAA. The CAA's lacked analysis of the findings.R2's EHR recorded a Significant Change MDS, dated 10/14/25, which triggered the Cognitive Loss/Dementia and Urinary Incontinence/Indwelling Catheter. The CAA lacked an analysis of the findings.R3's EHR recorded a Significant Change MDS, dated 09/17/25, which triggered the Cognitive Loss/Dementia, Communication, Functional Abilities, Urinary Incontinence/Indwelling Catheter, Nutritional Status, Dental Care, Pressure Ulcer, and Pain. The CAA lacked an analysis of the findings.R4's EHR recorded a Significant Change MDS, dated 12/2/25, which triggered the Cognitive Dental Care and Psychotropic Drug Use. The CAA lacked an analysis of the findings.R5's EHR recorded an Annual MDS, dated 11/24/25, which triggered the Cognitive Loss/Dementia, Urinary incontinence, Falls, Nutritional Status, Psychotropic Drug Use, and Pressure Ulcers. The CAA lacked an analysis of the findings.R7's EHR recorded an Annual MDS, dated 3/16/26, which triggered Functional Ability, Psychotropic Drug Use, Nutrition Status. The CAA lacked an analysis of the findings.R9's EHR recorded a Significant Change MDS, dated 6/20/25, which triggered Falls, and Psychotropic Drug Use. The CAA lacked an analysis of the findings.R10's EHR recorded a Significant Change MDS, dated 3/30/26, which triggered Visual Function. The CAA lacked an analysis of the findings.R12's EHR recorded an Annual MDS, dated 09/08/25, which triggered the Functional Ability. The CAA lacked an analysis of the findings.R15's EHR recorded an Annual MDS, dated 2/24/26, which triggered the Cognitive Loss/Dementia, Functional Abilities, Urinary Incontinence/ Indwelling Catheter, Falls and Nutritional Status. The CAA lacked an analysis of the findings.R22's EHR recorded a Significant Change MDS, dated 08/30/25, which triggered the Pressure Ulcer. The CAA lacked an analysis of the findings.R28's EHR recorded a Significant Change MDS, dated 12/16/25, which triggered the Psychotropic Drug Use. The CAA lacked an analysis of the findings.R61's EHR recorded an admission MDS, dated 3/10/26, which triggered the Cognitive Loss/Dementia. The CAA lacked an analysis of the findings.R71's EHR recorded an admission MDS, dated 10/27/25, which triggered the Cognitive Loss/Dementia, Psychotropic Drug Use, Psychosocial Well Being, Falls, Pain, Nutrition Status, Mood/Behavior, Pressure Ulcer. The CAAs lacked analysis of the findings.R91's EHR recorded an admission MDS, dated 3/21/26, which triggered the Urinary Incontinence/Indwelling Catheter, Psychosocial Well Being, Functional abilities, Falls, Nutritional Status, Pressure Ulcer, and Pain. The CAAs lacked analysis of the findings.F98's EHR recorded an admission MDS, dated 11/14/25, which triggered the Functional Abilities, Urinary Incontinence/Indwelling Catheter, Psychotropic Drug Use, Falls and Nutritional Status. The CAAs lacked analysis of the findings.On 04/28/26 at 07:48 AM interview with Licensed Nurse LN F reported she had stopped writing the CAA notes last year after being told by someone but could not remember who it was. That is why she did not write anything on the CAA that triggered. LN F revealed at times she would document risk concerns, but with everything was just on the main check-off on the worksheet and it was already on the MDS CAA section and why they triggered.The facility did not provide a policy regarding the CAA.

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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** Based on observation, record review and interviews, the facility failed to provide Resident (R)2 with a dignified existence by allowing his leg urinary catheter bag to remain on his lower leg, without a dignity bag or cover. Findings included:- R2's Electronic Medical Record (EMR) documented diagnoses which included: calculus in bladder (a hardened mass of minerals that forms within the urinary bladder when urine becomes highly concentrated or remains in the bladder for too long) and dementia (a progressive mental disorder characterized by failing memory and confusion). R2's inaccurate Significant Change Minimum Data Set (MDS), dated [DATE], documented he had a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. He was dependent on staff for toileting hygiene, had an indwelling urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag), and was always incontinent of urine. R2's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), triggered but lacked analysis of findings. R2's Quarterly MDS, dated [DATE], documented he had a BIMS score of one. He was dependent on staff for toileting hygiene, had an indwelling urinary catheter and was always incontinent of urine. R2's Care Plan, revised 03/23/26, instructed staff to cover his drainage bag with a privacy cover. On 04/27/26 at 09:59 AM, R2 sat in his wheelchair at the door of his room. His catheter drainage bag rested on his lower left leg supported by his shoe. The drainage bag, visible to visitors and other residents in the hallway, contained dark amber urine and lacked a privacy cover. On 04/27/26 at 11:45 AM, R2 sat in his wheelchair in the dining room. His catheter drainage bag continued to rest on his lower left leg supported by his shoe. The drainage bag, visible to visitors and other residents in the hallway, contained dark amber urine and lacked a privacy cover. On 04/27/26 at 11:49 AM, Certified Nurse Aide (CNA) M stated R2's catheter drainage bag will slide down to his lower left leg often. CNA M stated he had never placed a dignity bag on R2's drainage bag. On 04/28/26 at 07:17 AM, CNA N stated R2's urinary drainage bag would slide down from his left thigh to his lower left leg. Staff should move the drainage bag back up to R2's thigh when it slides down. CNA N stated the staff do not utilize catheter dignity bags on their hall. On 04/29/26 at 08:40 AM, Administrative Nurse E stated she had not given thought to staff utilizing dignity bags for urinary catheters on the memory care unit. The facility policy for Resident Rights, approved 12/2024, included: Each resident of the community has the right to a dignified existence including privacy and confidentiality.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interviews and record review, the facility failed to ensure residents received the opportunity to participate in the care planning process when staff failed to invite Residents (R) 10 and R11 or their responsible party to care plan meetings. Findings included:1. R10's Electronic Medical Record (EMR) recorded a admission Minimum Data Set (MDS) dated 01/14/26 and a Significant Change MDS dated 03/20/26, which documented a Brief Interview of Mental Status BIMS score of 12, indicating moderately impaired cognition. R10's EMR lacked documentation of a care plan meeting conducted in the past four months.On 04/27/26 at 09:28 AM, R10 reported she was not invited to any care plan meeting.2. R11's EMR recorded an admission MDS dated 02/20/26 and a Quarterly MDS dated 03/18/26, which documented a BIMS score of 14 indicating intact cognition. R11's EMR lacked documentation of a care plan meeting conducted in the past two months.On 04/27/26 at 12:10 PM, R11 reported she was not invited to any care plan meeting.On 04/29/26 at 10:36 AM, Administrative Nurse F reported residents and or the family members were mailed or given hand given invitations to attend care planning meetings. Administrative Nurse F reported that a copy of the invitation should be uploaded in the EMR. Administrative Nurse E said the Interdisciplinary Care Conference assessment should also be completed in the EMR and confirmed she could not locate any documentation for R10 or R11 for a care plan meeting being completed. The facility's policy Care Planning, undated, documented in addition to creating parts of the resident's comprehensive care plan, Social Service representative also needs to attend the care plan meetings. In these meetings, the team presents information to the resident and/or resident information about their progress towards their care plan goals. Federal law provides that, to the extent possible, the resident, the resident's family, or the resident's legal representative should participate in the care plan meeting. An Interdisciplinary Care Conference Notes Assessment (UDA) should be completed during the care plan meeting.

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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** Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 100's call light was within her reach. Findings included: - R100's Electronic Medical Record (EMR) documented a diagnosis of clostridium difficile (C-diff: contagious bacteria characterized by foul-smelling frequent loose bowel movements) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).R100's Entry Minimum Data Set was completed on 04/22/26 on her admission date. R100's admission Minimum Data Set (MDS), dated [DATE], documented that it was in progress. No information was available.R100's Base Line Care Plan, dated 04/23/26, documented staff to evaluate for change in level of consciousness. The base line care plan lacked documentation for a call light. On 04/28/26 at 08:06 AM, R100's door was closed to her room, and she could be heard yelling loudly for help several times. Licensed Nurse (LN) H asked if that was R100 yelling and donned his gown, mask, and gloves. LN H entered R100's room; she was lying on her left side in bed, and she reported she wanted to get up and she could not find her call light. R100's call light was observed on the floor under her bed.On 4/28/26 at 08:51 AM, Certified Nurse Aide (CNA) Q clipped the call light to R100's shirt with a black and silver binder clip. On 04/29/26 at 12:15 PM, R100 was in her room seated in the recliner and her call light was lying on the floor not in reach. R100 reported she wanted to go to bed and reported she could not get herself back in bed. On 04/28/26 at 09:46 AM, CNA Q reported that the binder clip was used to keep the call light attached to the resident and that the call light cord did not have a clip that was attached.On 04/29/26 at 12:18 PM, LN H reported the staff should make sure they clip the call light to the resident's clothes and reported that R100 would throw her call light on the floor. On 04/29/26 at 12:20 PM, Administrative Nurse D reported that she expected the staff to make sure all residents always have their call lights in reach. She was unsure about using a binder clip to hold a call light in place. The facility did not provide a policy about call lights.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment in Resident (R) 87's bathroom.Findings Included:- On 04/27/2026 at 11:41 AM, an environmental tour with Maintenance Staff UU revealed the following concerns in R87's bathroom and handwashing area:Approximate four-foot section of loose baseboard to the left of and behind the toilet. Black substance on the wall and floor behind the loose baseboard to the left of and behind the toilet.Approximate three-inch crack in the toilet seat.Empty Hand Soap dispenser hanging from the wall above the handwashing sink with exposed lag bolt fasteners.On 04/27/2026 at 11:41 AM, Maintenance Staff UU confirmed the above findings and stated the soap dispenser did not work. Maintenance staff UU confirmed the toilet seat should be replaced, the bathroom baseboard removed, the black substance tested for mold, and the sheetrock removed and replaced. Additionally, he stated the hand soap dispenser was mounted with lag bolts over a stud and not in the sheet rock as it should be to secure it to the wall to properly secure the dispenser.On 04/29/2026 10:26 AM, Maintenance Staff UU reported the facility implemented a QR code for staff and visitors to report maintenance items for repair. He confirmed the findings above had not been reported. He confirmed the area behind the handwashing sink had leaked and flowed into the bathroom area, so the sink had been replaced but he had no report of the findings above. Additionally, Maintenance Staff UU reported the facility did not have policies for maintenance repair in resident's room.The facility did not provide a policy for safe, homelike environment.

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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 assessments to reflect the resident's status for four residents: Resident (R) 2 related to incontinence of urine and dependence on the staff for activities of daily living (ADL), R3 related to restraints, R9 related to falls, and R10 related to Hospice services.Findings included:- R2's undated Physician Orders, documented pertinent diagnoses which included dementia.R2's 10/14/25 Significant Change in Status Minimum Data Set (MDS) documented Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. He had no impairment in functional limitation in range of motion. He was independent with eating and upper body dressing and used a walker and wheelchair (w/c) as mobility devices. R2 had an Indwelling catheter and coded as always incontinent of bladder.R2's 04/07/26 Quarterly MDS documented no changes in the assessment from above.Review of the EMR from 03/30/26 through 04/27/26 revealed no staff documentation regarding w/c mobility or dressing requirements.Review of the EMR from 03/30/26 through 04/27/26 revealed catheter care was provided each shift.On 04/27/26 at 09:59 AM, R2 sat slumped in the w/c in his room with his eyes closed, wearing a hospital gown. His indwelling urinary catheter collection bag attached to his left leg clearly visible, lacking a cover. On 04/27/26 at 11:45 AM, R2 sat in the dining room wearing a hospital gown. His urinary catheter collection bag remained on lower left leg, with spout on, lacking a cover.On 04/28/26 at 09:55 AM, Consultant MM was working with R2 in his room. R2 was wearing a green striped shirt and black pants with food crumbs on it. On 04/28/26 at 11:52 AM, CNA M put the resident's left foot on the foot pedal repeatedly when his foot fell from the foot pedal multiple times. CNA M continued to propel the resident into the dining room with his left foot skimming the floor. His black pants remain dirty.On 04/28/26 at 01:33 PM, CNA N and CNA M propelled the resident into the shower room in his w/c to provide peri-care. Both his feet skimmed the floor and both foot pedals were on the w/c. His black pants were still dirty. Staff assisted him to stand up to the handrail with extensive assistance. He was able to bear weight on both his legs but did not straighten his legs, remaining in a squatted position while standing. On 04/27/26 at 11:49 AM, CNA M stated the residents wear hospital gowns over their clothes while they eat, as they're used as clothes protectors, and the gowns are removed before they leave the dining room. CNA M also stated R2's catheter bag slides down to his lower leg all the time and they were unsure about dignity bags and never put his drainage bag in anything.On 04/28/26 at 07:17 AM, CNA N, stated the resident's urinary bag is attached to his left thigh and it shouldn't be down on his calf, but it slides down all of the time if his pants are loose. CNA N further stated if it was down his calf then staff would need to help him move it back up to his thigh area, and not to use dignity bags on the back on the unit. On 04/28/26 at 09:55 AM, Consultant M stated therapy has been working with him on w/c positioning and lateral supports in place and help the resident sit up straight.On 04/28/2 at 11:52 AM, CNA M stated the resident's left foot never stays on the foot pedal and he required total care and was dependent on staff to dress him.On 04/28/26 at 11:52 AM, CNA N stated the w/c foot pedals are pretty much useless as his feet always skim the floor while staff propel him in the wheelchair. CNA N stated the resident has had the catheter for a long time, more than a year. CNA N further stated he hasn't walked for several years, and he is dependent on staff for all his activities of daily living (ADLs). On 04/29/26 at 08:57 AM, Consultant NN reported she worked with R2 for standing strength, trying to have him use his hands more, standing strength, etc. but he doesn't stand up big and tall and kind of bent over. Consultant NN then stated he gets around well in his w/c and she worked with him last week.On 04/29/26 at 09:58 AM, LN G stated the resident does not walk, he can propel himself in his wheelchair and staff will propel him at times. LN G continued to state his feet do not always stay on the foot pedals and the foot pedals should be adjusted so that his feet stay on them and reported R2 has an indwelling catheter.On 04/29/26 at 09:02 AM, Administrative Nurse F stated she goes around with the GG form and talks (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with CNAs on first and second shift or will watch the residents as cares are being done to assess the residents to code the MDS. She reported R2's performance varies by day of what he can or cannot do. Administrative Nurse F stated she utilized the RAI Manual for guidance to complete the MDS accurately.On 04/29/26 at 08:40 AM, Administrative Nurse E stated the resident hasn't walked for several months and expects the staff to provide assistance with dressing when clothing is dirty and assist with positioning of his feet on the foot pedals while propelling him about the facility. She confirmed the resident had an indwelling catheter.- R3 undated physician orders documented diagnoses which included 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) with hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body).The 08/29/25 Significant Change in Status Minimum Data Set (MDS) documented a brief interview for mental status (BIMS) of 15, indicating intact cognition. She had functional limitation in range of motion on one side of her upper and lower extremities and required partial to moderate assistance with eating and substantial to maximum assistance with toileting, hygiene, dressing bed mobility; other restraint use indicated. On 04/28/2026 at 09:59 AM, R3 lay in bed with her right arm laying on pillow for positioning and bilateral grab bars at the head of the bed. R3 reported she uses the grab bars to help move and position in bed. No indication of any device which limits the resident's access to her body or voluntary movement.On 04/28/2026 at 09:34 AM, CNA Q, confirmed the facility did not use restraints, the grab bars at the head of the bed were there to help residents to reposition in the bed and to increase their independence.On 04/29/2026 at 12:43 PM, Administrative Nurse J confirmed the facility did not use any restraints and the grab bars were used as enablers to help residents to reposition in bed and to increase their independence; the MDS was inaccurate.On 04/29/2026 at 01:23 PM, Administrative Staff A confirmed facility did not use any restraints. The grab bars were used as enablers to help residents to reposition in bed and to increase their independence.- Resident (R) 9 pertinent diagnoses from physician's order EMR documented diagnoses which included diabetes, atrial fibrillation (irregular heartbeat), unsteadiness of feet, nondisplaced fracture of proximal phalanx of right lesser toes (broken toes).R9's Significant Change Minimum Data Set (MDS), dated [DATE], documented a brief interview for mental status (BIMS) of 13, indicating intact cognition. The resident required partial moderate assistance with transfer, no ambulation, and functional limitations in range of motion on one side of the lower extremities.The Quarterly MDS, dated [DATE], documented a BIMS of 13, indicating cognition; no changes in ADLs status. The MDS indicated he did not have falls. R9's EMR documented the resident experienced falls on 02/04/26 and 02/19/26.The Progress Notes (PN) documented falls as follows:02/04/2026 at 03:30AM, an aide notified a nurse that the resident was found on the floor. Upon entering the room, the resident was observed sitting on the floor on her buttocks next to the bed, leaning her head against the bed. A skin tear was noted on the right side of the forehead, measuring approximately 1 cm x 0.5 cm.When asked what happened, the resident stated, I was deep asleep and I just found myself on the floor with a lot of pain on my head Resident was alert and able to answer questions appropriately, she was able to move all four extremities without difficulty.02/19/2026 at 05:28 AM, Staff alerted the nurse that the resident was on the floor, staff walked in the room, found resident sitting on the fall mat on the floor. She landed on her buttock with legs straight, bed by her left side, and her walker across her. Staff assessed the resident head-to-toe related to unwitnessed fall, checked her skin, and noted a scratch on the right ankle.On 04/28/2026 at 08:12 AM, CNA delivered her tray while the lights are off, she sat up on the edge of her bed independently and reported she was asleep.- Resident (R) 10's pertinent diagnoses from physician's order electronic medical record (EMR) documented: diabetic mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), coronary artery disease (CAD- abnormal condition that may affect the flow of oxygen to the heart), and chronic kidney disease.R10's Significant Change Minimum Data Set (MDS), dated [DATE], (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented a brief interview for mental status (BIMS) of 12, indicating moderately impaired cognition, and no hospice.The Electronic Health Records (EHR) Hospice Certification and Physician Orders documented an order for hospice services to initiate 03/17/26.The Social Service Progress Notes (PN), dated 03/16/2026 at 01:56 PM, documented that the DPOA did not want to sign her mother on to services until tomorrow, and the referral packet was sent and the Director of Nursing (DON)/Administrator informed.On 04/28/26 at 02:30 PM, R10, while lying in bed, reported that she just got a bed bath from the hospice aide.On 04/27/26 at 04:25 PM, Consultant HH reported that she could not answer the question about the MDS, and would refer to regional consultant GG.On 04/28/26 at 12:40 PM, Certified Nurse Aide (CNA) Q reported R10 received hospice services which included bathing.On 04/28/26 at 03:16 PM, Licensed Nurse (LN) I confirmed R10 received hospice services.On 04/28/26 at 02:45 PM, Administrative staff A reported that the Resident Assessment Instrument (RAI) manual is used as the policy to guide staff in the accurate completion of the MDS complete for the MDS.04/29/2026 at 01:41 PM, Consultant MDS Nurse GG confirmed the above findings reflected an inaccurate assessment and reported that he expected the MDS to be accurate. He confirmed the above assessments were into completed in accordance with the Resident Assessment Instrument (RAI) User's Manual, the above assessments were not accurate due to the following:R2 should have been coded as not rated due to the placement of an indwelling catheter instead of incontinence of urine, and his ADL status was not accurately reflected when coded as independent. R3's grab bars were used as enablers and not restraints.R9 MDS failed to reflect the resident's fall, which occurred during the look back period.R10 related to Hospice services were received during the look back period and not coded in the MDS.The Center for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, dated 10/2017, documented a significant error is an error in an assessment where the resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and/or the error has not been corrected via submission of a more recent assessment. A significant error incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a summary of the baseline care plan to Resident (R) 100. Findings included:- R100's Electronic Medical Record (EMR) documented a diagnosis of clostridium difficile (C-diff: contagious bacteria characterized by foul-smelling frequent loose bowel movements) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).R100's Entry Minimum Data Set was completed on 04/22/26 on her admission date.R100's admission Minimum Data Set (MDS), dated [DATE], documented it was in progress. No information was available.R100's Base Line Care Plan, dated 04/23/26, documented contact precautions. Staff were educated to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard, and bag the linens and close the bag tightly before taking it to laundry.On 04/27/26 at 10:10 AM, R100 reported she did not know what a base line care plan was.On 04/28/26 at 08:06 AM, R100's door was closed to her room, and she could be heard yelling loudly for help several times. Licensed Nurse (LN) H asked if that was R100 yelling and donned his gown, mask, and gloves. LN H entered R100's room she was lying on her left side in bed. R100 said she wanted to get up, but she could not find her call light. R100's call light was observed on the floor under her bed.On 04/28/26 at 03:16 PM, LN I reported that the baseline care plan was started on the day the resident was admitted . She reported that the nurse would review the baseline care plan with the resident, but the charge nurse would not give the resident or family member a written copy of the base line care plan.On 04/29/26 10:36 AM, Administrative Nurse F reported that she would review the baseline care plan with the resident and/family and reported she had completed an Interdisciplinary Care Conference 48 Hours on 04/27/26. Administrative Nurse F reported that the computer must not have kept the care conference note, as it was not opened or completed in R100's EMR. Administrative Nurse F reported she thought the Social Service Designee (SSD) would have completed the care conference last week then reported that the facility had not had a SSD for three weeks now, then she changed what she had said and reported the family could not come in until 04/27/26 and could not state why there was not a opened or completed Interdisciplinary Care Conference 48 Hours completed as of 04/29/26.The facility did not provide a policy for base line care plans.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate activity of daily living (ADL) assistance to Resident (R)2 regarding changing clothing.Findings included:- R2's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion).R2's Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. The MDS inaccurately documented that he required setup assistance with lower body dressing.R2's Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 10/14/25, did not trigger.R2's Quarterly MDS, dated [DATE], documented the resident had a BIMS score of one, indicating severe cognitive impairment. The MDS inaccurately documented that he required setup assistance with lower body dressing.R2's Care Plan, revised 03/23/26, inaccurately instructed staff that the resident was independent with dressing.R2's EMR lacked staff documentation of the resident's ADL needs.On 04/28/26 at 09:55 AM, R2 sat in his wheelchair in his room. He wore black pants with food crumbs on them.On 04/28/26 at 11:52 AM, Certified Nurse Aide (CNA) M propelled the resident in his wheelchair from his room to the dining room. R2 continued to wear dirty black pants.On 04/28/26 at 01:33 PM, CNA M and CNA N changed the R2's dirty pants using total assistance. R2 was unable to participate in dressing or undressing.On 04/28/26 at 11:52 AM, CNA M stated residents should be dressed in clean clothing when they go into the dining room for a meal. CNA M stated the resident required total assistance with dressing.On 04/28/26 at 09:58 AM, Licensed Nurse (LN) G stated staff should make sure the residents are always dressed in clean clothing. LN G stated the resident required total staff assistance with dressing.On 04/29/26 at 10:08 AM, Administrative Nurse E stated it was the expectation for staff to ensure residents are always dressed in clean clothing. Administrative Nurse E confirmed the resident required total staff assistance with dressing.The facility policy for Activities of Daily Living, revised 09/24/25, included: The facility shall provide each resident with care, treatment, and services according to the resident's individualized care plan.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent the development of and promote the healing of pressure ulcers when staff failed to ensure R101 received necessary interventions including a low air loss mattress, heels were offloaded, and a consistent repositioning plan. Findings included: - R101's Electronic Medical Record (EMR) revealed diagnoses of incomplete quadriplegia (spinal cord injury occurring at the neck where the cord is not fully severed, leaving some sensory or motor function below the injury level), limited mobility, and muscle weakness.R101's 03/11/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R101's MDS documented no behaviors or refusals of care, and he required maximal assistance with activities of daily living (ADL) including bed mobility to roll left and right. The MDS recorded he had a Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer that was not present on admission. R101's MDS documented a pressure-reducing device was in his wheelchair and bed, and R101 was on a turn and reposition program.R101's 03/26/25 Pressure Ulcer/Injury Care Area Assessment (CAA) lacked an analysis of the findings.R101's admission Data Collection, dated 03/06/25 at 12:56 PM, documented R101 had an actual skin impairment on the sacrum but lacked documentation of what the actual skin impairment was, or what preventative skin care was needed.R101's Braden Scale (scale used to predict pressure ulcer risk), dated 03/06/25 at 04:09 PM, documented a score of 16, which indicated the resident was at risk.R101's Care Plan, dated 03/07/25, directed staff to float R101's heels while in bed and provide a pressure reduction cushion to protect his skin while up in the chair.R101's 03/06/25 Physician's Orders documented Triad paste (zinc-oxide-based, hydrophilic paste used to manage, protect, and heal moderate to heavily weeping wounds, especially in difficult-to-dress areas. It adheres to both wet and dry skin, making it effective for wounds in areas with excessive moisture) daily to the coccyx (area of skin over the tailbone) for prevention at bedtime for skin integrity. The order was discontinued on 03/07/25.R101's Interdisciplinary Care Conference 48 Hours, dated 03/07/25 at 11:33 AM, documented R101's only skin issue was a surgical site on his cervical spine.R101's Care Plan, dated 03/10/25, instructed staff to position R101 every two hours and as needed or requested for pain relief, pressure reduction and comfort. Staff were instructed R101 required two staff participation to reposition and turn in bed.R101's Weekly Skin Check, dated 03/11/25 at 05:38 AM, documented a superficial open area approximately 7.0 centimeters (cm) by 5.0 cm on the left buttock; the care plan was not reviewed, and the area was new per the documentation.R101's Daily Skilled Progress Note on 03/11/25 at 12:37 PM documented no new skin distress noted.R101's Skin and Wound Evaluation, dated 03/11/25 at 05:22 PM, documented a Stage 2 partial-thickness skin loss with exposed dermis noted on the left gluteal fold (pertaining to the buttocks or buttocks muscles), facility (in-house) acquired on 03/11/25, and measured 7.1 cm by 4.2 cm with preventative moisture barrier and control. The skin and wound evaluation was not checked off for a turning and repositioning program as an additional care.R101's 03/12/25 Physician's Orders documented apply Triad paste to the left buttock wound, nickel thick, every day and night shift, and as needed, for wound care.R101's Care Plan, dated 03/12/25, instructed staff to apply moisture barrier with each incontinent episode.R101's Daily Skilled Progress Note on 03/12/25 at 12:23 PM documented no new skin distress noted.R101's Daily Skilled Progress Note on 03/12/25 at 11:43 PM documented new skin area, with a treatment in place.R101's 03/19/25 Physician's Orders documented a right heel, deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or bloodˆfilled blister due to damage of underlying soft tissue from pressure and/or shear), and to apply skin-prep (liquid skin protectant) and a foam dressing every day shift on every Monday, Wednesday, Friday and as needed for wound care.R101's Skin and Wound Evaluation, dated 03/19/25 at 10:22 AM, documented DTI of the right heel, facility acquired on 03/19/25 measured 4.0 cm by 3.2 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cm with preventive measures of air mattress and heel protection device.R101's 03/19/25 Physician's Orders documented C-boots (special boots designed to offload pressure) to be worn while in bed every day and night shift for skin integrity.R101's Skin and Wound Evaluation, dated 03/19/25 at 10:26 AM, documented Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) in-house acquired pressure area of the left gluteal measured 9.0 cm by 6.9 cm, with preventative moisture barrier and air mattress. The skin and wound evaluation was not checked off for turning and repositioning program as an additional care.R101's Care Plan, dated 03/19/25, instructed staff to avoid shearing (the separation of skin layers caused by friction or trauma) while repositioning R101 in bed related to his wound and to monitor pressure areas for changes in color, sensation, temperature, and report any change to nurse. Staff were instructed to offload pressure from his heels while up in chair.R101's 03/21/25 Physician's Orders documented a left buttock coccyx wound; cleanse with normal saline or wound cleanser, apply Hydrofera Blue (a type of moist wound dressing that provides wound protection and addresses bacteria and yeast) and foam dressing every day shift, every Monday, Wednesday, Friday and as needed for wound care.R101's Weekly Skin Check, dated 03/24/25 at 10:39 AM, documented no new changes. The care plan updated question was answered as non-applicable because the care plan was current, an update was not needed.R101's Skin and Wound Evaluation, dated 03/26/25 at 04:41 PM, documented a DTI of the right heel in-house acquired on 03/19/26 measured 3.5 cm by 3.1 cm with preventive measures of a heel protection device.R101's Skin and Wound Evaluation, dated 03/26/25 at 04:45 PM, documented an unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) in-house acquired pressure ulcer of the left gluteus on 03/12/25, which measured 9.6 cm by 5.4 cm with preventative measures of an air mattress. The skin and wound evaluation was not checked off for a turning and repositioning program as an additional care.R101's Skin and Wound Evaluation, dated 03/31/25 at 11:46 AM, documented a DTI of right heel, in house acquired on 03/19/26, which measured 3.3 cm by 2.3 cm, with preventive measures of heel protection device.R101's Skin and Wound Evaluation, dated 03/31/25 at 12:29 PM, documented an unstageable in-house acquired pressure ulcer of the left gluteus which measured 11.2 cm by 3.3 cm with preventative measure of an air mattress. The skin and wound evaluation was not checked off for turning and repositioning program as an additional care.R101's EMR lacked evidence of nutritional notes related to the wounds.R101's EMR lacked evidence that a low air loss mattress was offered and declined or provided.R101's EMR under Tasks lacked evidence of a turning and repositioning program. The EMR further lacked documentation that R101 refused repositioning.R101's EMR documented that he discharged from the facility on 04/04/25.On 04/28/26 at 09:46 AM, Certified Nurse Aide (CNA) S reported when a resident was on a turn and position program, the staff would know as it would be scheduled in the tasks in EMR for the staff sign out after they completed a task. CNA S reported she did not have access to the care plan or Kardex. She reported she relied on the other staff to let her know if a resident required preventative measures.On 04/28/26 at 12:40 PM, CNA Q reported that the staff are required to document in point of care (POC) in EMR for residents that have a turn, and position scheduled every two hours. CNA Q reported staff are to document as soon as the task is completed. CNA Q reported if a resident required to have their heels elevated and or wear booties that would also be under the tasks for the staff to document if they completed the task or if the resident refused. CNA Q reported she did not know about the Kardex in the residents EMR.On 04/28/26 at 03:16 PM, Licensed Nurse (LN) I reported that if a resident was noted with a new wound or skin area the nurse would notify Administrative Nurse E (Wound Nurse) and the provider. LN I stated the nurse should assess and obtain orders for treatments, and implement preventative interventions like booties. LN I reported that Administrative Nurse E or Administrative Nurse F (MDS Nurse) were responsible for scheduling any task on POC and said that the nurses could not add a task. LN I reported the scheduled Tasks was how the staff would know how to complete tasks that were required.On 04/29/26 at 09:30 AM, Administrative Nurse E reported that R101 was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted on [DATE] and a foam dressing was ordered as preventative treatment. She reported that R101 did not have any open areas until 03/11/25. She said R101 would refuse to turn in bed but confirmed that it was not documented in R101's EMR. Administrative Nurse E reported that the staff should primarily know if a resident required to be turned and positioned every two hours if a resident were bedridden. Administrative Nurse E reported that she thought the Tasks in the EMR generated a turn and reposition program for the staff to sign off when completed or refused and verified that R101 did not have a turn and reposition program scheduled when he was a resident there. Administrative Nurse E reported R101 did not have an air mattress when he was a resident there and said she thought he was offered an air mattress and declined but could not locate any documentation in R101's EMR regarding that. Administrative Nurse E reported that she expected the nurse to obtain an order and document on the same day a wound is assessed that the treatment was completed.On 04/29/26 at 11:03 AM, Administrative Nurse F reported the turn and repositioning program would be scheduled in POC for the residents that required turn and positioning assistance. She stated she thought that when she clicked on the care plan for turn and reposition required, it was system generated so the CNAs could document that task.On 04/29/26 at 02:05 PM, Regional Consultant HH reported that R101 had a turn and reposition on his Kardex when he admitted . Consultant HH reported that is how the CNAs knew when a resident required assistance. Administrative Staff A reported that it was just a given, or known fact, that the residents require to be turned and positioned every two hours and reported the turn and reposition program was not available on POC when R101 was a resident here. Administrative Staff A and Consultant Staff HH reported they expected residents would not receive facility acquired pressure ulcers.The facility's policy Skin Identification, Evaluation, and Monitoring, dated 02/2026, documented the purpose of this policy is to outline a method of identification, evaluation, and monitoring for alterations in skin integrity. Communities will implement preventative measures, and an individualized care plan will be formulated upon completion of findings. Complete Braden Skin at Risk on admission, then weekly for the next three weeks following admission. Initiate preventative and/or treatment intervention as indicated. Notify community wound care nurse, and Director of Nursing of pressure injury identification. Update baseline care plan with initial interventions. Schedule regular and frequent repositioning for bed and chair bound residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an environment free from accident hazards when staff failed to utilize appropriate foot pedals when propelling Resident (R) 2 in his wheelchair causing his feet to not remain safely on the foot pedals during transportation.Findings included:- R2's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion).R2's inaccurate Significant Change Minimum Data Set (MDS), dated [DATE], documented he had a Brief Interview for Mental Status (BIMS) score of one, indicating severe cognitive impairment. The MDS noted R2 was independent with walking with the use of a walker and/or wheelchair.The Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 10/14/25, did not trigger.R2's inaccurate Quarterly MDS, dated [DATE], documented he had a BIMS score of one. The MDS noted R2 was independent with walking with the use of a walker and/or wheelchair.R2's Care Plan, revised 03/23/26, instructed staff R2 had cognitive impairment due to a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R2's care plan lacked staff instruction on the use of foot pedals while propelling him in his wheelchair.On 04/28/26 at 11:52 AM, Certified Nurse Aide (CNA) M propelled the resident in his wheelchair from his room to the dining room for lunch. R2's wheelchair had foot pedals in place, however R2's shoed left foot fell from the foot pedal and skimmed the floor in between the foot pedals during transport.On 04/28/26 at 01:33 PM, CNA N propelled R2 from the dining room into the shower room to provide care. R2's wheelchair had foot pedals in place, however, both of R2's shoed feet skimmed the floor in between the foot pedals during transport.On 04/28/26 at 11:52 AM, CNA M stated R2's left foot never stayed on the foot pedal of his wheelchair.On 04/29/26 at 11:52 AM, CNA N stated the foot pedals of R2's wheelchair were useless as he was not able to keep his feet on the foot pedals.On 04/29/26 at 09:58 AM, Licensed Nurse (LN) G confirmed R2's feet did not always remain on the foot pedals of his wheelchair when he was propelled by staff. LN G stated the foot pedals should be adjusted to better fit R2's needs.On 04/29/26 at 08:40 AM, Administrative Nurse E stated it was the expectation for staff to ensure R2's feet remained on the foot pedals of his wheelchair during transport; if R2's feet did not remain on foot pedals, staff would need to lower them to better fit the resident.The facility did not provide a policy regarding wheelchair safety.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Residents (R)28 remained free from unnecessary medications when staff failed to administer as needed (PRN) bowel medication for constipation.Findings included:- R28's Electronic Medical Record (EMR) documented a diagnosis of constipation (difficulty passing stools).R28's Significant Change Minimum Data Set (MDS), dated [DATE], documented he had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS noted he was always incontinent of bowel and had no constipation.R28's Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA), dated 12/16/25, triggered but lacked an analysis of findings.R28's Quarterly MDS, dated [DATE], documented he had a BIMS score of 11, indicating moderately impaired cognition. The MDS noted he was always incontinent with his bowel.R28's Care Plan, revised 02/23/26, documented R28 had episodes of bowel incontinence and instructed staff to use disposable briefs.R28's EMR under the Orders tab, included the following physician's orders:Docusate sodium (a stool softener used to assist in the passing of stool), 100 milligrams, by mouth, every 12 hours, PRN, for a diagnosis of constipation, ordered, 10/22/25.Glycolax (a laxative used to assist in the passing of stool), 17 grams, by mouth, every 8 hours, PRN, for a diagnosis of constipation, ordered 10/22/25.R28's EMR under the Task tab revealed he did not have a bowel movement (BM) on the following dates:No BM from 04/05/26 through 04/09/26, for a total of five days.No BM from 04/21/26 through 04/25/26, for a total of five days.R28's Medication Administration Record (MAR) for April 2026 lacked documentation that staff administered either of the PRN medications.On 04/28/26 at 01:45 PM, Certified Nurse Aide (CNA) N stated R28 did have periods of constipation. CNA N stated all BMs were documented in the EMR.On 04/29/26 at 09:58 AM, Licensed Nurse G confirmed the resident did not have a BM on the dates noted and staff had not administered PRN medication for bowels.On 04/29/26 at 10:08 AM, Administrative Nurse E stated it was the expectation for nurses to administer PRN medications when a resident did not have a BM for three or more days.The facility did not provide a policy regarding bowel management.

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F 0814 Level of Harm - Potential for minimal 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.Findings included:- During the initial tour of the kitchen on 04/27/26 at 08:57 AM, observation revealed the two doors to the outside dumpster were open. The ground around the dumpster was littered with used disposable gloves, used hairnets, empty restaurant take-out containers, and other unidentifiable objects. On 04/28/26 at 01:57 PM, Dietary Staff BB stated the doors to the dumpster were often not closed by staff after disposing of trash, as required.The facility did not have a policy regarding keeping the doors of the dumpster closed.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe and sanitary environment in the facility laundry.Findings included:- On 04/28/2026 at 11:55 AM, inspection of the laundry with Housekeeping/Maintenance Staff WW revealed the following concerns:Unsealed concrete floor surfaces throughout the laundry room floor.A folding tabletop had missing laminate and exposed wood.Shelving in the clean laundry area had exposed bare wood.Missing paint on the ceiling area approximately one foot by two feet. Eighteen broken tiles on the laundry floor folding area. A three-foot section of clean linen shelving and upright post had bare wooden shelves with exposed wood. The second shelf from the bottom corner pf the wooden shelving unit was missing paint. The dryer room ceiling had cardboard taped to the ceiling approximately four inches by eight inches.On 04/28/2026 at 12:04 PM, Housekeeping/Maintenance Staff UU agreed the above findings needed fixing and the shelves should be replaced. He reported the hole in the ceiling was due to a vent cover being removed and said the opening was covered with cardboard and tape.On 04/29/2026 at 10:26 AM, Housekeeping/Maintenance Staff UU reported the facility did not have policies to address laundry maintenance and repairs.