STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175281	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kansas City	3231 N 61st Street Kansas City, KS 66104

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 57 residents. The sample included 15 residents, with two reviewed for reasonable accommodation of needs related to assistive devices. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)2's wheelchair foot pedals were utilized while being pushed. The facility additionally failed to ensure R43 had a way to communicate her needs due to her call lights being left out of reach. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings included:- The Medical Diagnosis section within R2's Electronic Medical Records (EMR) noted 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), muscle weakness, and a history of falls. R2's Quarterly Minimum Data Set (MDS) completed 06/27/25 revealed a Brief Interview for Mental Status Score of 14, indicating severe cognitive impairment. The MDS noted she had no upper or lower extremity impairments. The MDS noted she used a wheelchair for mobility. The MDS noted she required supervision or touch assistance for bed mobility, transfers, dressing, bathing, toileting, personal hygiene, and putting on footwear. The MDS noted she had a history of falls. R2's Falls Care Area Assessment (CAA) completed 06/13/25 indicated she had a history of falls related to generalized weakness and her medical diagnoses. The CAA noted she used a wheelchair. The CAA indicated that a care plan was implemented to minimize her risk of falls. R2's Care Plan initiated on 11/28/20 indicated she required assistance with her activities of daily living (ADLs). The plan noted she had a history of falls related to her medical diagnoses. The plan indicated signage was placed in her room to call for help. The plan instructed staff to ensure she wore non-skid footwear before transferring. The plan indicated that her room was to have non-skid traction tape placed on her bedroom and bathroom floors to prevent falls. The plan noted she used a wheelchair for mobility. On 08/20/25 at 11:17 AM, a Certified Nurse's Aide (CNA) stated staff were expected to use the foot pedals when pushing residents in their wheelchairs. On 08/20/25 at 11:24 AM, Administrative Nurse D stated staff should not be pushing residents in their wheelchairs without using foot pedals to prevent their feet from dragging or being a fall risk. The facility's Fall Management System, revised 03/2025, indicated the facility promoted an environment that remains free from accident hazards. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred. - R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypothyroidism (a condition characterized by decreased activity of the thyroid gland), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), muscle weakness, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness, fracture with routine healing, and hypoxia (inadequate supply of oxygen). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R43 was rarely or never understood. The MDS documented R43 was dependent on staff for all ADLs. R43 's Tube Feeding Care Area Assessment (CAA) dated 09/18/24 documented that R43 was nothing by mouth (NPO) and received tube feeding continuously. The CAA documented R43 receives hydration through tube feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube), and nursing administers the feeding and hydration per the physician's orders.R43's Care Plan dated 05/13/24 indicated R43 required staff assistance for her activities of daily living and was at risk for falls related to her medical diagnoses. The plan instructed staff to ensure her call light remained within reach and staff provided assistance as needed. On 08/18/25 at 08:34 AM, R43 lay in her bed on her back with her eyes shut. R43 had a thick yellow substance on her lips and in her mouth. On 08/19/25 at 02:12 PM, R43's call light lay between R43's bed and her roommate's bed on the floor. R43's call light was not within her reach.On 08/20/25 at 11:17 AM, the Certified Nurse Aide (CNA) M stated that call lights were to be placed within the resident's reach at all times. On 08/20/25 at 11:24 AM, Administrative Nurse D stated staff were expected to check the call light placement during each encounter to ensure the residents could communicate their needs. The facility's Fall Management System, revised 03/2025, indicated the facility promoted an environment that remains free from accident hazards. The policy indicated the facility appropriately assessed and implemented interventions to

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. The facility identified a census of 57 residents. The sample included 15 residents, with one reviewed for privacy. Based on observation, record review, and interviews, the facility failed to secure protected health information (PHI) for Resident (R) 31. This deficient practice placed R31 at risk for decreased psychosocial well-being due to a lack of privacy. Findings Included: - On 08/18/25 at 07:39 AM, a walkthrough of the 100 Hall revealed an unattended nursing cart across the hallway from the nurse's station. An inspection of the cart revealed R2's PHI displayed on the cart. At 08/18/25 at 07:40 AM, Licensed Nurse (LN) H exited a room in the 100 Hall and locked the computer screen. On 08/20/25 at 11:01 AM, LN G stated the computer was to be locked when not attended by staff to protect health information. On 08/20/25 at 11:40 AM, Administrative Nurse D stated staff were expected to lock the computer screens when they were not in use to protect the residents' PHI. A review of the facility's Resident Rights revised 09/2024 indicated the facility will ensure each resident's privacy and ensure all residents were educated and informed of their rights.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 57 residents. The sample included 15 residents, with two residents reviewed for the discharge process. Based on observation, record review, and interviews, the facility failed to provide a final summary of the resident's status at discharge for Resident (R) 64 and R1. This deficient practice placed R64 and R1 at risk of delayed care or uncommunicated care needs.Findings Included: - R64's “Electronic Medical Records” (EMR) documented diagnoses of malnutrition (consuming to few calories), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), cancer of the rectum, muscle weakness, unsteadiness on feet, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dysphagia (swallowing difficulty), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R64's Modification of Admissions Minimum Data Set (MDS) completed 05/13/25 noted a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented that he had an impairment of her lower extremity. The MDS documented R64 needed supervising or touching assistance with eating and oral hygiene, and partial/moderate assistance with toileting and bathing. R64’s “Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA), dated 05/13/25, documented generalized muscle weakness and was on skilled services, nursing assisted with activities of daily living (ADLs) function as needed, and staff to place R64’s call light within his reach. R64’s EMR recorded a “Discharge Assessment-Return Not Anticipated MDS” documenting R64's discharge date d 06/24/25. R64’s “Care Plan,” revised 07/07/25, documented the discharge plan was to go home after therapy services. The plan of care for R64 documented the facility would develop and follow a full discharge plan with a comprehensive plan. R64’s EMR under “Progress Notes” revealed a “Nursing Note” dated 06/24/25 that documented R64’s caregiver was at the facility to pick up R64 and take him home. R64 refused his medications; he stated he wasn't going to take them, and the caregiver agreed. R64’s belongings were packed and given to him. R64 left in a personal car. Paperwork was sent with R64. R64’s “Discharge Charge Summary” was undated and lacked documentation showing recompilation of his stay in the facility. On 08/20/25 at 11:01 PM, Licensed Nurse (LN) G stated it was the responsibility of the nurse who was on duty when a resident was discharged from the facility. He stated the nurse would document in the resident's nursing notes what the facility had done for the resident, where the resident was going, what he took with him, the medications he had, what the facility did with the medications, and what follow-up appointments the resident had scheduled. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/25 at 11:24 PM, Administrative Nurse D stated it was the nurse on duty’s responsibility to document a recompilation of the resident's stay in the facility, which included where his medication was sent, where the resident was going, and what the facility had done for the resident. The facility’s “Discharge Summary” dated 09/05/25 documented that the social services and nursing staff participate in developing a discharge summary when a resident is discharged to a private residence, another nursing facility, or another type of residential facility. The discharge summary provides a recapitulation of the resident’s stay and the resident’s status at the time of discharge to ensure continuity of care. Facilities will complete the discharge summary located in PointClick Care unless state policy requires the use of a state-mandated discharge summary form. - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of respiratory failure with hypoxia (inadequate supply of oxygen), dyspnea (difficulty breathing), insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The “admission Minimum Data Set (MDS)” dated 03/13/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 was independent with activities of daily living (ADL). The Quarterly MDS dated [DATE] documented a BIMS score of 14, which indicated intact cognition. The MDS documented that R1 was independent with his ADLs. R1’s Cognitive Loss/Dementia Care Area Assessment (CAA)” dated 03/19/25 documented R1 had verbal behaviors directed toward other residents. R1's “Care Plan,” dated 07/16/25, documented nursing staff would discuss the history of hospitalization with him and family. The plan of care documented the staff would educate him and his family on his current health condition and self -manager. R1‘s EMR under the “Progress Notes” tab revealed the following “Health Status Note” on 05/30/25 at 06:36 PM: R1 was transferred to the hospital. On 08/19/25 at 11:41 AM, R1 sat outside the facility in his wheelchair during an activity. R1 visited with staff and other residents. On 08/20/25 at 11:02 AM, Licensed Nurse (LN) G stated he would have the resident sign the facility’s bed hold policy prior to the transfer to the hospital and give the resident a copy of the policy. LN G stated he called the resident’s family or their legal representative to notify them of the transfer. LN G stated he did not notify the family or representativity in writing. On 08/20/25 at 11:25 AM, Administrative Nurse D stated the written notification to the resident’s legal representative was provided by the social service department. Administrative Nurse D stated the bed hold policy was sent with the resident at the time of transfer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility’s “Bed-Hold Policy,” last revised 08/05/25, documented the bed-hold policy would be given upon admission, upon transfer of a resident to the hospital (if in an emergency within 24 hours), or the resident goes on therapeutic leave of absence. The facility would provide written information to the resident or resident representative, the nursing facility's policy on bed-hold periods, and the resident's return to the facility to ensure that residents are made aware of a facility’s bed-hold and reserve bed payment policy before and upon transfer to ahospital or when taking a therapeutic leave of absence from the facility.

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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** The facility identified a census of 57 residents. The sample included 15 residents, with two residents reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure that cleaning of her mouth was provided for Resident (R) 43, who required assistance from staff to complete the care. This deficient practice placed R43 at risk for complications, including discomfort related to poor personal hygiene.Findings included:- R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypothyroidism (a condition characterized by decreased activity of the thyroid gland), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), muscle weakness, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness, fracture with routine healing), and hypoxia (inadequate supply of oxygen).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R43 was rarely or never understood. The MDS documented R43 was dependent on staff for all ADLs. R43's Tube Feeding Care Area Assessment (CAA) dated 09/18/24 documented R43 was nothing by mouth (NPO) and received tube feeding continuously. The CAA documented R43 receives hydration through tube feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube), and nursing administers the feeding and hydration per the physician's orders.R43's Care Plan dated 05/13/24 documented R43 had oral/dental health problems (inflamed gums) related to poor oral hygiene and was NPO. R43's plan of care documented mouth care was to be provided at least daily. R43's plan of care directed staff to provide mouth care daily, and staff were to report any abnormalities to nursing. On 08/18/25 at 08:34 AM, R43 laid in her bed on her back with her eyes shut. R43 had a thick yellow substance on her lips and in her mouth. On 08/20/25 at 11:01 AM, Licensed Nurse (LN) G stated that the cleaning of a resident's mouth that had an internal feeding was not documented anywhere. He stated staff know residents with internal feedings need their mouths cleaned at least every shift. On 08/20/25 at 11:17 AM, the Certified Nurse Aide (CNA) M stated it was all the nursing staff's responsibility to ensure residents stay clean. CNA M stated normally, the LN was the person who cleaned residents' mouths when the resident had an internal feeding because they were in her room more often. She stated it was all the nursing staff's responsibility to ensure the residents are clean. On 08/20/25 at 11:24 AM, Administrative Nurse D stated residents should have their mouths cleaned when a staff member sees the resident's mouth is dirty. She stated that all residents should be clean and that it was every staff member's responsibility. The facility's Activities of Daily Living policy dated 09/25/25 documented the resident would receive assistance as needed to complete activities of daily living. The quality-of-care fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care by professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

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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** The facility identified a census of 57 residents. The sample included 15 residents, with two residents reviewed for treatment/services to prevent/heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure-reducing measures were placed on Resident (R) 58's bilateral lower extremities to prevent pressure ulcers. This placed R58 at increased risk for pressure ulcer development. Findings Included:- R58's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), 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), muscle weakness, communication deficit, need for assistance with person care, history of falling, disruption of wound, encephalopathy (a broad term for any brain disease that alters brain function or structure), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left dominant side. The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R58 was never or rarely understood. The MDS documented R58 was at risk for pressure ulcers. The MDS documented R58 needed supervision or touching assistance to roll from right to left. The MDS documented R58 had a pressure-reducing mattress in her wheelchair and her bed. R58's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 05/29/24 documented R58 had a history of pressure injury. The CAA documented staff were to apply barrier cream to her buttocks for protection, and Skin-prep (liquid skin protectant) to bilateral heels.R58's Care Plan dated 05/21/25 documented R58 was at risk for skin integrity. The plan of care for R58 had a Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) on the left heel, which had healed. R58's plan of care documented to maintain intact skin with no breakdowns, R58 used a pressure-reducing mattress, and staff would perform weekly skin checks. R58's EMR under the Order tab documented the following physician orders:Bilateral boots were on even when she was in bed. Remove boots every shift to examine skin, related to disruption of wound, dated 03/14/25.Skin prep wipes were applied to the bilateral heel topically every shift related to the disruption of the wound, dated 03/14/25. The Braden Scale (a scale for predicting pressure sore risk) dated 07/25/25 documented a score of 12, which indicated a high risk for pressure wounds. On 08/19/25 at 02:14 PM, R58 laid on his bed on his back; R58's heels were directly on his mattress. On 08/20/25 at 11:01 AM, Licensed Nurse (LN) G stated that if a resident were to have boots applied to their heels, it would be a nursing duty and would be on the Treatment Administration Record (TAR). He stated it would be a nursing duty, and the nurse would ensure the boots were on the residents' feet. On 08/20/25 at 11:17 AM, Certified Nursing Aide (CNA) M stated that if a resident was to have their heels floated or boots applied to heels, it would show on the CNAs documentation and the charge nurses' documentation. She stated that all nursing staff would know that the residents' heels were to float, or boots needed to be applied to their heels. On 08/20/25 at 11:24 AM, Administrative Nurse D stated ensuring boots were applied to a resident's heels was ultimately the nursing duty and would be on the TAR. She stated the nurse could delegate the task to a CNA but would need to ensure the task was followed through. The facility's Skin Integrity and Pressure Ulcer/Injury Prevention and Management reviewed 03/31/23 documented the facility would provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 57 residents. The sample included 15 residents, with two residents reviewed for position and mobility. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 54 was given (ROM- the full movement potential of a joint, usually its range of flexion and extension) exercises to prevent contractures (abnormal permanent fixation of a joint or muscle) and help with R54's flaccid left hand. This deficient practice left R54 at risk for further decline and decreased range of motion or mobility. Findings included:- R54's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left non-dominant side, muscle weakness, need for assistance with personal care, dysphagia (swallowing difficulty), history of falling, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R54 was independent with eating, needed setup or cleanup for oral hygiene, and was partial/moderate assistance from staff for toileting, bathing, and dressing. R54's Functional Abilities Care Area Assessment (CAA) dated 05/09/24 documented R54 had a cerebral infarction with one-sided weakness and used his wheelchair for locomotion. R54's Care Plan dated 08/27/24 documented R54 had weakness and a decrease in physical mobility related to a cerebral accident. The plan of care documented R54 required extensive assistance from one staff member for locomotion using a wheelchair. The plan of care documented the staff were to observe and report any immobility, contractures forming or worsening. The plan of care for R54 documented the nursing and restorative aide were to perform active ROM to the bilateral lower extremities for 20 minutes. Review of R54's EMR documented no indication that ROM exercises were performed. R54's EMR documented no refusals of ROM exercises. On 08/20/25 at 11:01 AM, Licensed Nurse (LN) G stated the facility does have a restorative Certified Nurse's Aide (CNA). He stated the facility had been understaffed, and the restorative aide had been pulled to the floor to work as a CNA and was unable to do her restorative duties. On 08/20/25 at 11:17 AM, CNA M stated she was the restorative aide. She stated the facility was now fully staffed, and there was a plan in place for her to start doing exercises daily with the residents. On 08/20/25 at 11:24 AM, Administrative Nurse D stated the facility had been short-staffed, and the restorative aide was not able to work as a restorative aide. She stated the facility did have a plan in place to ensure the restorative program was in place. The facility's Restorative Nursing policy, reviewed on 09/20/24, documented that the restorative program was to promote the resident's optimum function. A restorative program may be developed by proactively identifying, care planning, and monitoring of a resident's assessments and indicators. Nursing Assistants must be trained in the techniques that promote resident involvement in restorative activities.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility had a census of 57 residents. The sample included 15 residents, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure 44 E pressurized medical oxygen tanks in a safe, locked area, and out of reach of the eight cognitively impaired, independently mobile residents. The facility further failed to ensure R2's fall interventions were in place. This deficient practice placed the residents at risk for preventable accidents and injuries.Findings Included:- On 08/18/25 at 07:56 AM, an inspection of the facility’s oxygen storage room revealed that the door was not secured. An inspection of the room revealed 44 full E-supplemental oxygen cylinders in the storage racks. The door had a keypad and did not lock when the door was shut. On 08/19/25 at 07:22 AM, an inspection of the facility’s oxygen storage room revealed that the door was not secured. An inspection of the room revealed 44 full E-supplement oxygen cylinders in the storage racks. The door had a keypad and did not lock when the door was shut. On 08/20/25 at 08:22 AM, the facility identified it had eight cognitively impaired, independently mobile residents. On 08/19/25 at 07:25 AM, Licensed Nurse (LN) H stated the oxygen room should be unlocked. On 08/20/25 at 11:17 AM, Certified Nurse’s Aide (CNA) M stated the room had been unlocked, and she was unsure if the room should be locked or unlocked. On 08/20/25 at 11:24 AM, Administrative Nurse D stated staff were expected to ensure the door was locked upon entering and exiting the room. She stated the room should always be locked. The facility’s “Oxygen Administration (Safety, Storage, Maintenance) revised 10/11/24 documented it was the policy of the facility to ensure that oxygen was administered and stored safely within the healthcare centers or in an outside storage area. - The Medical Diagnosis section within R2’s Electronic Medical Records (EMR) noted 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), muscle weakness, and a history of falls. R2’s “Quarterly Minimum Data Set (MDS)” completed 06/27/25 revealed a Brief Interview for Mental Status Score of 14, indicating severe cognitive impairment. The MDS noted she had no upper or lower extremity impairments. The MDS noted she used a wheelchair for mobility. The MDS noted she required supervision or touch assistance for bed mobility, transfers, dressing, bathing, toileting, personal hygiene, and putting on footwear. The MDS noted she had a history of falls. R2’s “Falls Care Area Assessment (CAA)” completed 06/13/25 indicated she had a history of falls related to generalized weakness and her medical diagnoses. The CAA noted she used a wheelchair. The CAA indicated that a care plan was implemented to minimize her risks of falls. (continued on next page)

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	175281	A. Building B. Wing	08/20/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2’s “Care Plan” initiated on 11/28/20 indicated she required assistance with her activities of daily living (ADL). The plan noted she had a history of falls related to her medical diagnoses. The plan indicated signage was placed in her room to “call for help”. The plan instructed staff to ensure she wore non-skid footwear before transferring. The plan indicated her room was to have non-skid traction tape placed on her bedroom and bathroom floors to prevent falls. A review of R2’s EMR under “Census” revealed she was moved to a new room on 08/01/25. The EMR indicated she had no falls since being moved to her new room. On 08/18/25 at 07:34 AM, an inspection of R2’s room revealed no traction tape or signage posted in R2’s bedroom or bathroom. On 08/20/25 at 11:17 AM, Certified Nurse’s Aide (CNA) M stated R2 recently moved room and her fall interventions should have been transferred to her new room. On 08/20/25 at 11:01 AM, Licensed Nurse (LN) G stated staff were expected to ensure the interventions were in place each shift and transfer the implemented fall interventions when a resident was moved to a new room. On 08/20/25 at 11:24 AM, Administrative Nurse D stated R2 was recently moved to a different room, and her fall interventions should have been transferred to her new room. She stated staff were expected to inspect her room and ensure the fall interventions were implemented. The facility’s “Fall Management System,” revised 03/2025, indicated the facility promoted an environment that remains free from accident hazards. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 57 residents. The sample included 14 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities regarding the lack of monitoring antihypertensive (a class of medication used to treat high blood pressure) medications for Resident R10. These deficient practices placed these residents at risk for adverse medication effects and unnecessary medications.Findings included:- R10's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of adult failure to thrive, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and hypertension (HTN- elevated blood pressure). The admission Minimum Data Set (MDS) dated 04/21/25 documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R10 required substantial to maximum assistance with her activities of daily living (ADLs). The Quarterly MDS dated [DATE] documented a BIMS score of 14, which indicated intact cognition. The MDS documented that R10 required substantial to maximum assistance with her ADLs. R10's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 04/24/25 documented she was alert and oriented and able to communicate her needs, but had cognitive impairment. R10's Care Plan, dated 04/15/25, documented staff would administer her medication as ordered by the physician. R10's EMR under the Orders tab revealed the following physician orders: Toprol XL (antihypertensive) oral tablet extended release 24-hour 25 milligram (mg) (metoprolol succinate), give three tablets by mouth at bedtime for chronic heart failure and high blood pressure dated 04/12/25. Review of R10's Medication Administration Record (MAR), Treatment Administration Record (TAR), and her EMR from 05/01/25 to 08/19/25 (111 days) lacked consistent heart monitoring for antihypertensive medication Toprol. Review of the Monthly Medication Review (MMR) from August 2024 to July 2025 lacked documented recommendations for heart monitoring for R10's antihypertensive medication orders for hold parameters and physician notification. On 08/19/25 at 11:41 AM, R10 laid asleep on her bed. R10 was covered with a blanket, call light was on the bed next to her. On 08/20/25 at 11:02 AM, Licensed Nurse (LN) G stated antihypertensive medication should be monitored. LN G stated that if an order lacked physician-ordered parameters, he would call and clarify the antihypertensive order. On 08/20/25 at 11:25 AM, Administrative Nurse D stated there should be monitoring for antihypertensive medication. Administrative Nurse D stated she would expect the CP to identify the lack of correct monitoring for medications.The facility's Pharmacy Services and Medication Regimen Review policy last reviewed 09/16/23 documented the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing (DON).

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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** The facility identified a census of 57 residents. The sample included 14 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to follow the pharmacist's recommendation for the monitoring of antihypertensive (a class of medication used to treat high blood pressure) medications for Resident R10. These deficient practices placed these residents at risk for adverse medication effects and unnecessary medications.Findings included:- R10's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of adult failure to thrive, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and hypertension (HTN- elevated blood pressure). The admission Minimum Data Set (MDS) dated 04/21/25 documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R10 required substantial to maximum assistance with her activities of daily living (ADL). The Quarterly MDS dated [DATE] documented a BIMS score of 14, which indicated intact cognition. The MDS documented that R10 required substantial to maximum assistance with her ADLs. R10's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 04/24/25, documented she was alert and oriented and able to communicate her needs, but had cognitive impairment. R10's Care Plan, dated 04/15/25, documented staff would administer her medication as ordered by the physician. R10‘s EMR under the Orders tab revealed the following physician orders:Toprol XL (antihypertensive) oral tablet extended release 24-hour 25 milligram (mg) (metoprolol succinate), give three tablets by mouth at bedtime for chronic heart failure and high blood pressure, dated 04/12/25. Review of R10's Medication Administration Record (MAR), Treatment Administration Record (TAR), and her EMR from 05/01/25 to 08/19/25 (111 days) lacked consistent heart monitoring for antihypertensive medication Toprol. On 08/19/25 at 11:41 AM, R10 laid asleep on her bed. R10 was covered with a blanket, call light was on the bed next to her. On 08/20/25 at 11:02 AM, Licensed Nurse (LN) G stated antihypertensive medication should be monitored. LN G stated if an order lacked physician-ordered parameters, he would call and clarify the antihypertensive order. On 08/20/25 at 11:25 AM, Administrative Nurse D stated there should be monitoring for antihypertensive medication. Administrative Nurse D stated she would expect the CP to identify the lack of correct monitoring for medications.The facility was unable to provide policy-related medication monitoring.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility reported a census of 57 residents. The facility identified four medication carts. Based on observations, record review, and interviews, the facility failed to secure medication at the nurse's station. This deficient practice placed the residents at risk for unnecessary medication and administration errors. Findings included:On 08/18/25 at 07:45 AM, an inspection of the 200 Hall revealed a bottle of ocular vitamins dated 07/07/25 left unsecured on the counter at the nurse's station. The bottle contained the warning Keep out of reach of children, in case of accidental overdose, get medical help or contact poison control center right away.On 08/18/25 at 07:50 AM, Licensed Nurse (LN) G secured the vitamins and stated the medications were to be locked up in the nurse's carts and not left out at the station. On 08/20/25 at 11:24 AM, Administrative Nurse D stated medications were to be locked up at all times and out of reach of the residents. The facility's Medication Access and Storage policy, revised 09/2024, indicated the facility was to ensure all medications and biologicals remained locked and secured to prevent tampering or exposure to the environment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 57 residents. The facility had one kitchen. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to overflowing trash and food storage. This deficient practice placed the residents at risk for food-borne illness.Findings included:- During the initial tour on 08/18/25 at 07:33 AM, observation revealed the following:The kitchen floor was sticky. In the small one-door freezer, there was food wrapped in plastic wrap that appeared to be fish, unlabeled and undated. In the two-door freezer, there was a bottle of pink Minute Maid lemonade, a tub of ice cream, and a bag of cookie dough opened and undated.The green trash bins were overflowing with trash, next to the stove, uncovered. On 08/18/25 at 07:46 AM, Dietary Staff BB stated all foods should be dated and labeled. She stated the kitchen floor was sticky and would be cleaned. Dietary Staff BB stated that the trash should not be overflowing and should always be covered.The facility's Food Safety policy dated 05/01/25 documented that food was stored and maintained in a clean, safe, and sanitary manner following federal, state, and local guidelines to minimize contamination and bacterial growth.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. The facility identified a census of 57 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program including antibiotic stewardship for the residents of the facility. Findings included: - Review of the Infection Control Log for tracking and trending infections from August 2024 through July 2025, lacked evidence of tracking and identification of possible infection outbreaks at the facility, lacked consistent identification of infection, and of antibiotic administration. The facility was unable to provide evidence of the documentation of continent documentation of the infection control surveillance from August 2024 through March 2025. On 08/19/25 at 03:23 PM, Administrative Nurse E, the facility's Infection Preventionist (IP), stated she had just started as the IP in April 2025. Administrative Nurse E stated she was unable to answer whether the previous IP had tracked the antibiotic administration, tracking, and trending of clusters of infections or organisms. The facility's Antibiotic Stewardship policy, last revised 07/22/25, documented the antibiotic stewardship program promoted the appropriate use of antibiotics and included a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This meant that the antibiotic was prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms and/or other adverse events. The program would be managed and overseen by the Infection Preventionist.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 57 residents. The sample included 14 residents, with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer or obtain informed declinations or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20 - vaccination for bacterial infections), and pneumococcal (type of bacterial infection) vaccination for Resident (R) 1, R7, and R29. This placed the residents at increased risk for complications related to pneumonia. Findings included:- Review of R1's clinical record revealed the Pneumococcal Polysaccharide Vaccine (PPSV23) was offered and declined on 09/13/24. R2's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. Review of R7's clinical record revealed the Pneumococcal Polysaccharide Vaccine (PPSV23) was offered and declined on 10/07/24. R7's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication. On 08/20/25 at 11:02 AM, Licensed Nurse (LN) G stated a resident was offered vaccination at the time of admission. LN G stated if the resident consented for any vaccinations, the vaccination would be ordered from the pharmacy. LN G stated the order would be placed on the Medication Administration Record (MAR). LN G stated the vaccination would be given upon delivery from the pharmacy and then documented in the resident's electronic medical record (EMR) under the Immunization tab. On 08/20/25 at 11:25 AM, Administrative Nurse D stated the residents were offered immunizations at the time of admission. Administrative Nurse D stated Administrative Nurse E was responsible to track and ensure the vaccinations offered. The facility's Pneumococcal Vaccine Policy for Residents policy, last reviewed 07/08/25, documented each resident would be offered pneumococcal immunization, unless the immunization was medically contraindicated, or the resident has already been immunized. There would be documentation in the medical record if there is reason to believe that pneumococcal vaccine(s) was given previously, but the date cannot be verified, and this had an impact upon the decision regarding administration of the vaccine(s).