STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175287	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eureka Nursing Center	1020 N School Street Eureka, KS 67045

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately, to prevent the potential for foodborne bacteria. Findings included:- During an initial tour of the resident kitchenette, on 04/13/26 at 08:07 AM, the following areas of concern were noted in the one facility kitchen:1. The bottom shelf of the worktable holding the food processor had a build-up of food debris and dried-on fluids.2. A cart holding clean serving plates contained food debris.3. A stainless steel shelf holding clean serving pots had a build-up of food debris.4. A plastic trash can next to the steam table had dried-on food and fluids on the lid and sides.5. A large, white plastic container used to store thickener had a clear, sticky substance on top.6. Two reach-in freezers in the dry storage room had food debris scattered on the bottom. Review of the Weekly Cleaning schedule revealed the dietary staff was to clean the bottom of prep tables weekly on Mondays. Review of the Weekly Cleaning schedule lacked a day for dietary staff to clean the inside of the reach-in freezers. On 04/15/26 at 11:07 AM, Dietary Staff BB confirmed the areas of concern need to be cleaned on a more regular basis. The facility policy for Dietary Cleaning Procedures, undated, included: The facility shall store, prepare, and distribute food under sanitary conditions to ensure proper food handling practices to prevent the outbreak of foodborne illnesses.

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 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. Based on observation and interview, the facility failed to promote dignity for one resident, Resident (R)42, who was using her fingers to get thickened juice out of her cup because staff failed to identify and assist or offer a spoon. Findings included:- On 04/14/26 at 09:20 AM, during a meal observation, R42 sat at a table attempting to drink her thickened juice. She put the glass to her lips and tried to drink it, but it was too thick. After trying to drink it several times without success, R42 dipped her right index finger into the juice to scoop it out to eat it. Dietary Staff CC walked over to her table, turned to the surveyor and said, She likes to make a mess, then proceeded to wipe the table. The surveyor questioned if the resident might do better with a spoon and Dietary Staff CC stated, Ya, I guess I can get her a spoon. Dietary Staff CC provided R42 a spoon, and the resident was able to spoon her thickened juice and eat it.On 04/15/26 at 12:25 PM, Administrative Nurse D stated R42 should have been assisted and given a spoon so she would not have to use her finger.The facility's Promoting/Maintaining Resident Dignity policy, undated, documented that the practice of the facility was to protect and promote resident rights and treat each resident with respect and dignity, as well as care for each resident in a manner and in an environment that maintained and enhanced the resident's quality of life by recognizing each resident's individuality.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to provide the resident (or their representative) a Skilled Nursing Facility Advanced Beneficiary Notice (ABN) and Notice of Medicare Non-Coverage (NOMNC) for skilled services when Resident (R) 54's skilled services ended. Findings included:- On 04/14/26 at 09:12 AM, ABN and NOMNC notices were requested for R54, R7, and R19. The facility was unable to provide R54's NOMNC related to the end of the skilled services. R54's start of skilled stay began on 01/04/26 and ended on 02/16/26. On 04/14/26 at 11:55 AM, Administrative Staff A confirmed she had not located the NOMNC for the end or R54's end of skilled services provided by the facility. The facility's undated Advanced Beneficiary Notices policy documented that a NOMNC, Form CMS-10123, shall be issued to the resident/representative when Medicare-covered service(s) are ending, no matter if the resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO). This notice is used when all covered services end for coverage reasons and an exhaustion of benefits is not considered a termination for coverage reasons.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide privacy for Residents (R)4 and R3, while staff performed cares in their rooms. Findings included:1. R5's Electronic Medical Record (EMR) documented a diagnosis of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R5's re-admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. He was dependent on staff for bed mobility. R5's Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 01/28/26, documented the resident required staff assistance for completion of ADLs due to generalized weakness. R5's Care Plan, dated 01/09/26, instructed staff that he required assistance of one to two staff for bed mobility. R5's EMR from 03/16/26 through 04/12/26 under the TASK tab, revealed he was dependent on staff for bed mobility. On 04/13/26 at 12:57 PM, Certified Medication Aide (CMA) S, CMA R and Licensed Nurse (LN) G provided cares for the resident in his room. The resident rested on his right side naked from his mid chest to his feet. While LN G and CMA S provided cares, CMA R exited and entered the room to gather supplies, without covering the resident. The room lacked a privacy curtain. On 04/13/26 at 12:57 PM, CMA S stated R5 should have been covered before she exited and then re-entered the room. On 04/13/26 at 12:57 PM, CMA R confirmed staff had not covered R5, leaving him mostly naked on his bed, when CMA exited and re-entered the room. 2. R3's EMR documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R3's Quarterly MDS, dated [DATE], documented a BIMS score of six, indicating severe cognitive impairment. She was dependent on staff for bed mobility. R3's Care Plan, dated 09/29/25, instructed staff she required assistance of one to two staff for turning and repositioning in bed. On 04/13/26 at 12:37 PM, CMA S and CMA R and LN G provided peri-care (cleansing of the genitals) for the resident in her room. The residents' bed was directly in front of the window with the blinds open for the duration of the care. On 04/13/26 at 12:57 PM, CMA S stated the window blinds should have been closed before beginning resident care. On 04/13/26 at 12:57 PM, CMA R confirmed the residents' window blinds were not closed before resident cares. On 04/15/26 at 07:51 AM, Administrative Nurse D stated it was the expectation for staff to ensure all residents' privacy while providing cares in their rooms. The facility policy for Promoting/Maintaining Resident Dignity, undated, included: The facility shall maintain resident privacy at all times.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 6 and R46 were free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication without an appropriate indication of use. Findings Included:- R6's Electronic Medical Record (EMR) documented diagnoses of insomnia, amnesia (inability to sleep), hostility, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, chronic kidney disease, chronic anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues) secondary to blood loss, and low back pain. R6's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R6 had intact cognition and no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or behaviors. The MDS documented that R6 received an antipsychotic antidepressant (a class of medications used to treat mood disorders) and an anticoagulant (a class of medications used to prevent the blood from clotting). The antipsychotic was received on a routine basis, had no gradual dose reduction (GDR), and no physician documentation of GDR as clinically contraindicated. R6's Psychotropic Drug Use Care Area Assessment (CAA), dated 10/02/25, documented the CAA triggered secondary to the use of psychotropic (affects mood or thoughts) medication, with contributing factors of depression and ongoing use of psychotropic medication. The pharmacist conducted periodic reviews of the medication regimen and provided recommendations, including consideration for dose reductions. R6's Care Plan dated 06/18/25, documented R6 had some issues with his short-term memory and a history of behaviors that included rejection of care and verbal aggression towards staff. The plan further documented that R6's medical record indicated a history of hostility and depression, and he was taking an antidepressant as well as an antipsychotic. The plan directed staff to monitor for side effects and adverse reactions of antipsychotic and psychoactive medications. The Physician Order dated 12/18/25, directed staff to administer quetiapine (antipsychotic) 25 milligrams in the evening, related to hostility. The Pharmacy Consultant Note dated 02/04/26, documented R6's drug regimen and chart had been reviewed for appropriateness regarding diagnosis, monitoring, duplication, duration, dosage, drug-to-drug interactions, drug-disease interactions, allergies, black box warning, Food and Drug Administration (FDA) labeling, off-label indications, and standard of care. The note regarding GDR, documented with recent adjustments, had been made to the psychotropic regimen, and would give four to six months to fully stabilize before entertaining the need for GDR with Trazodone increase on 01/2026. The note lacked a rationale for the continued use of Quetiapine for unapproved use for hostility. R6's chart lacked evidence of physician documentation of the rationale and risks versus benefits regarding the use of quetiapine and lacked documentation of the nonpharmacological interventions that were attempted and unsuccessful prior to initiation of antipsychotic medication. On 04/14/26 at 09:57 AM, R6 was in the hallway. He stopped and talked to staff and other residents. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He talked about his spouse's death in December and said the holiday was rough on him. He wished his children would visit more often. On 04/15/26 at 09:02 AM, Certified Medication Aide (CMA) S reported that the only behavior she had witnessed had been a slight sexual comment since his wife died. CMA S reported that R6 corrected his statement. CMA S stated R6 was kind and helped look after the other residents. On 04/15/26 at 10:10 AM, Licensed Nurse (LN) G reported she had not heard or seen R6 exhibit hostility or behaviors. On 04/15/26 at 11:45 AM, Administrative Nurse D reported the pharmacist attempted to ensure the physician had an appropriate diagnosis for the use of quetiapine, but the physician failed to document a rationale for the use. The undated facility's Use of Psychotropic Medication policy documented that psychotropic medications are to be used only when the practitioner determines that the medication is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. The resident's medical record shall include documentation of evaluation and the rationale for chosen treatment options. This includes any indicated documentation of the rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication. Adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. Also, adequate indication for use means that the medication administered is consistent with the manufacturer's recommendations and/or clinical practice guidelines, clinical standard of practices, medication references, clinical studies, or evidence-based review of articles that are published in medical and/or pharmacy journals. - The Electronic Medical Record (EMR) for R46 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance, and major depressive disorder (a major mood disorder that causes persistent feelings of sadness). The Annual MDS, dated 03/31/26, documented R46 had a BIMS score of 14, indicating intact cognition. R46 required partial staff assistance for showers, dressing, and eating. The MDS documented R46 rejected care daily and received antipsychotic and antidepressant medication on a routine basis. R46's 03/17/26 Care Plan included the following interventions for R46: 04/27/21- Attempt to identify a cause of behaviors, assess for pain, offer food, fluids, and toileting. Attempt to visit with me one-on-one as needed. I would like my physician to manage my medications and care. I have refused psychiatric services (specialized medical, behavioral, and therapeutic care focused on diagnosing, treating, and preventing mental, emotional, and behavioral disorders). 10/08/21- I have a history of urinating and having bowel movements in inappropriate places. Should (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	you notice me attempting to do this, please redirect me to a bathroom. 10/19/22- I have episodes of agitation where I curse at staff. When this occurs, remind me that this is inappropriate behavior and attempt cares at a later time as needed. 10/20/22- Staff has reported that they have noticed that there are ties that I have increased agitation with morning cares, at times yelling at staff. 03/19/24- I have a history of making sexually inappropriate comments toward female staff. Should you notice this, please remind me that these comments are inappropriate and are unacceptable. 10/25/24- Administer medications as ordered and monitor for effectiveness and adverse reactions. Notify the physician as indicated. R46's Orders tab of the EMR documented an active order dated 06/10/25 for Zyprexa (an antipsychotic medication), 2.5 milligrams (mg), by mouth, to be administered in the evening, for dementia without behavioral disturbances. The EMR lacked documentation of an appropriate indication for use of R46's prescribed Zyprexa and a risk versus benefit for the continued use of the Zyprexa medication. On 04/14/26 at 08:00 AM, R46 ambulated down the hall with his walker, accompanied by Social Service X. On 04/14/26 at 02:25 PM, Administrative Nurse D stated she was aware that the diagnosis of dementia was not approved by the Centers for Medicare and Medicaid Services (CMS), and she, as well as the pharmacist, had discussed this with the physician, but had not been given a different diagnosis or risk versus benefit for the medication. The facility's Use of Psychotropic Medication policy, undated, documented that the residents only received psychotropic medications when all other nonpharmacological interventions were clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience. The policy documented a clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals, and after any other treatments have been clinically contraindicated, a psychotropic medication would be prescribed.

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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 the record review and interview, the facility failed to provide a baseline care plan for Resident (R) 49. Findings included:- R49's Electronic Medical Record (EMR) documented diagnoses of thyrotoxicosis (excessive amount of thyroid hormone in the body), chronic kidney disease, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), heart failure, and displaced supracondylar fracture with intercondylar extension of the lower end of the right femur (a complex high-energy break of thigh bone just above the knee). The Entry Tracking Minimum Data Set (MDS), dated [DATE], documented that R49 had entered (admitted) to the facility. R49's MDS, dated [DATE], documented a modification of discharge, return anticipated/end of a Medicare Part A stay. R49's EMR lacked evidence of a baseline care plan. On 04/14/25 at 11:41 AM, upon request for R49's baseline care plan, Administrative Staff A reported the facility lacked a baseline care plan and said she expected the staff to have completed a baseline care plan in the required timeframe. The facility's Resident Centered Care Plan Process dated 03/28/18, documented that a baseline care plan will be developed within 24-48 hours after a resident's admission that will include individualized interventions based on the assessed needs and condition of the resident at the time of admission, and the minimum healthcare information necessary to properly care for the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an individualized person-centered care plan for Resident 49's stay, which began on 12/17/25 and ended on 01/15/26. Findings included:- R49's Electronic Medical Record (EMR) documented diagnoses of thyrotoxicosis (excessive amount of thyroid hormone in the body), chronic kidney disease, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), heart failure, and displaced supracondylar fracture with intercondylar extension of the lower end of the right femur (a complex high-energy break of thigh bone just above the knee). The Minimum Data Set MDS, dated [DATE], documented that R49 had entered (admitted) to the facility. R49's admission MDS, dated 12/24/25, documented R49 had intact cognition, required partial/moderate assistance with personal hygiene and upper body dressing, substantial/maximal assistance with bed mobility and transfers, and was dependent on toileting hygiene, lower body dressing, and putting on and taking off footwear. R49 was frequently incontinent of urine, received scheduled pain medication, as-needed (PRN) pain medication, and non-medication interventions for pain. The MDS further documented that R49 had a history of falls with fracture before admission, with major surgery requiring skilled nursing facility (SNF) care. R49 required major surgery for repair of the fractured leg/knee, had a surgical wound and pressure ulcer/injury upon admission. R49 received occupational and physical therapy with the overall goal of being discharged to the community. The Care Area Assessments (CAA) triggered by the MDS, dated [DATE], included functional abilities, urinary incontinence, falls, nutritional status, pressure ulcers, and pain. The CAAs documented that a comprehensive care plan would be initiated. R49's EMR had a Nutritional Care Plan dated 12/20/26, documenting that R49 had a nutritional risk related to decreased appetite, lack of mobility, and wounds. The plan directed staff to monitor weights and provide diet and supplements as ordered. The Progress Note dated 12/17/25 at 04:17 PM, documented the admission of R49 with a right femur fracture, who was alert and oriented, and had a regular diet order. The note further documented that R49 required two staff assistance with transfers with a gait belt. The Progress Note dated 01/15/26 at 06:36 AM documented that R49 was transported by emergency medical services to the hospital emergency room. On 04/14/25 at 11:41 AM, upon request for R49's comprehensive care plan, Administrative Staff A reported the facility lacked a comprehensive care plan and said she expected the staff to have completed a comprehensive care plan in the required timeframe. The facility's Resident Centered Care Plan Process dated 03/28/18, documented within seven days of completion of the initial comprehensive MDS, the interdisciplinary team will develop a comprehensive care plan for each elder that includes measurable objectives and timetables to meet each elder's clinical, nursing, mental, cultural, and psychosocial needs that are identified in the comprehensive assessment.

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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 adequate activity of daily living (ADL) cares to Resident (R)5 regarding showering. Findings included:- R5's Electronic Medical Record (EMR) documented a diagnosis of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R5's re-admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. He was dependent on staff for showering. R5's Activity of Daily Living Care Area Assessment (CAA), dated 01/28/26, documented the resident required staff assistance for completion of ADLs due to generalized weakness. R5's Care Plan, dated 01/09/26, instructed staff he required assistance of two staff for showering. R5's EMR from 03/16/26 through 04/12/26 (27 days) revealed staff showered the resident four times. The EMR lacked any further documentation of showering or rejection of care. On 04/13/26 at 08:45 AM, R5 sat in his wheelchair in his room. He had dirty, greasy hair. On 04/14/26 at 09:01 AM, R5 sat in his wheelchair in the front commons area. He continued to have dirty, greasy hair. On 04/13/26 at 08:45 AM, R5 stated he does not get enough showers. He said he would like to be showered two or three times per week. On 04/13/26 at 12:57 PM, Certified Medication Aide (CMA) S stated the residents were to be showered at least twice per week On 04/13/26 at 12:57 PM, CMA R stated there was a showering schedule in the nurse's station. Residents were to be showered twice weekly but could be showered more often if they chose. On 04/14/26 at 02:03 PM, Licensed Nurse (LN) G stated residents were to be showered twice weekly. If a resident refused a shower, it would be documented in the EMR. On 04/15/26 at 07:51 AM, Administrative Nurse D stated it was the expectation for residents to be showered twice weekly, depending on their preferences. The facility policy for ADL, undated, included: A resident who was unable to carry out ADLs will receive the necessary services to maintain personal hygiene.

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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 evaluate the effectiveness of fall interventions for Resident (R)8, who had multiple falls, and revise with person-centered fall interventions to prevent further falls. Findings included:- The Electronic Medical Record (EMR) for R8 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type 2 with neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). The Annual Minimum Data Set (MDS), dated [DATE], documented that R8 had a Brief Interview for Mental Status (BIMS) of four, indicating severely impaired cognition. R8 required substantial staff assistance for toileting, personal hygiene, showers, and lower-body dressing. The MDS further documented R8 required supervision with mobility, transfers, and was non-ambulatory. R8 had no functional impairment, had no falls since the prior assessment, and did not ambulate. The Annual MDS, dated 02/22/26, documented R8 had a Brief Interview for Mental Status of 3, indicating severely impaired cognition. R8 was dependent upon staff or toileting, showers, dressing, personal hygiene, and substantial staff assistance for mobility and transfers. The MDS further documented R8 had no functional impairment, had one non-injury fall, and did not ambulate.The Fall Risk Assessments, dated 02/18/25, 04/28/25, 06/19/25, 07/30/25, 12/12/25, 03/03/26, and 03/08/26 documented R8 was at risk for falls.R8's 02/04/26 Care Plan included the following interventions for R8:04/25/22 - I like to wake up early in the morning, usually around 07:00 AM, and prefer to take a shower every other day in the morning.09/18/24 - Toileting program of prompt and assist at 07:00 AM, 10:00 AM, 01:00 PM, 04:00 PM, 08:00 PM, at night, 04:00 AM, and as needed.04/28/25 - Offer me to lie down after meals, and hourly checks while in bed.06/19/25 - Prompt assist with toileting at 03:00 AM.07/30/25 - Prompt and assist with toileting at 06:00 AM.The Fall Investigation, dated 06/19/25 at 04:00 AM, documented R8 was found lying prone on the floor of her room in front of the bathroom. R8 was unable to explain what happened or what she was doing. There was urine on the floor from the bed to where she was lying. R8 sustained an abrasion (scrape) with a hematoma (collection of blood trapped in the tissues of the skin resulting from trauma). The immediate intervention was to adjust the toileting plan to toilet at 03:30 AM instead of 04:00 AM if awake.The Fall Investigation, dated 07/30/25 at 06:15 AM, documented that staff alerted the nurse that R8 was on the floor in her room. R8 was seated on the floor with her left leg under her beside the bed, with the wheelchair to the left side and the bed to the right, facing the wall. R8 had an old abrasion to the right knee with a little blood, and a small, reddened area was noted beside the left outer knee. R8 was able to move all extremities per normal and was assisted by two staff into her wheelchair. R8 was noted to be incontinent with urine and bowel. The immediate intervention was for staff to prompt and assist with toileting at 06:00 AM.The Fall Investigation, dated 12/25/25 at 05:29 AM, documented R8 was on the floor behind the door with blood coming from her forehead. R8 cried in pain, pressure and ice were applied to her head wound to stop the bleeding. R8's right kneecap was bruised and had two scratches on it. R8 went to the emergency room for evaluation and received sutures to her forehead. The immediate intervention was to prompt and assist with toileting at 05:00 AM. The care plan lacked documentation the intervention was put into place.The Fall Investigation, dated 03/03/26 at 04:15 PM, documented R8 fell in the shower room. She was in the shower chair and began to yell when the Certified Nurse Aide (CNA) assisted her. The nurse was in the shower room with the CNA when the nurse left the shower room to get wipes for R8. When the nurse entered the shower room, R8 was observed lying on her right side outside of the shower. R8 sustained a skin tear that measured 2.5 centimeters (cm) x 0.1 cm on the left forearm. Staff assessed R8, and she was assisted into her wheelchair by five staff members. The (continued on next page)

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	175287	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eureka Nursing Center	1020 N School Street Eureka, KS 67045

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention was to provide R8 with a shower upon awakening or be given a whirlpool. The care plan lacked documentation the intervention was put into place.The Fall Investigation, dated 03/08/26 at 05:55 AM, documented R8 was found next to her bed on her knees and left arm on the floor. R8 was dressed in a gown and barefoot. R8 was assisted into her wheelchair. The recommended intervention was to have staff position her wheelchair at the bedside, so if she transferred herself, her wheelchair was in a locked and ready position. The care plan lacked documentation the intervention was put into place.On 04/14/26 at 09:07 AM, CNA O placed a gait belt around R8's waist. Certified Medication Aide (CMA) T and CNA O assisted R8 to stand up and pivoted her into her wheelchair. CMA T stated R8 had not had any recent falls. CMA T stated they have to keep a close eye on her because when she wakes up, they must be ready to get her up.On 04/15/26 at 08:30 AM, Administrative Nurse E stated he had not printed the care plan that was kept at the nurse's station for staff to access and update as needed. Administrative Nurse D also stated he had not updated the care plan with current interventions.On 04/15/26 at 09:00 AM, she stated she was unaware that R8's last three fall interventions were not on the care plan. When they close out the investigation, she documents the intervention that was to be put into the care plan. Administrative Nurse E further stated that R8 fell in the shower after she had scooted to the edge of the wheelchair, and the CNA told her to please wait for the nurse to come in, but she did not and scooted out of the wheelchair.The facility's Fall Prevention Program policy, undated, documented that each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The facility provides interventions that address unique risk factors measured by the risk assessment tool. Interventions would be monitored for effectiveness, and the care plan would be revised as needed.

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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 observation, interview, and record review, the facility failed to adequately monitor R35's amlodipine (antihypertensive (high blood pressure medication). The facility failed to ensure R16 was free from unnecessary medication. Findings included:- R16's Electronic Medical Record (EMR) documented diagnoses of hypertensive (elevated blood pressure) heart disease with heart failure, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, and dementia (a progressive mental disorder characterized by failing memory and confusion). R16's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R16 had moderately impaired cognition and had wandering behavior one to three days of the look-back period. R16 was independent with functional abilities and mobility. R6 was occasionally incontinent of urine and always continent of bowel. The MDS further documented that R16 received an antianxiety (a class of medications that calm and relax people), an anticoagulant (a class of medications used to prevent the blood from clotting), an antibiotic (a class of medication to treat infections), a diuretic, an opioid (a class of medication to treat pain), and an anticonvulsant (a class of medications used to treat seizures). R16's Care Plan dated 06/16/25, documented R16 had a history of urinary tract infections (UTI) and was at risk for worsening incontinence and UTI due to decreased mobility, impaired memory, and high caffeine intake. The plan further documented that R16 was typically independent for toileting hygiene and transfers. The plan directed staff to monitor/document signs and symptoms of UTI, including pain, burning, blood-tinged urine, cloudiness, no output, deepening or urine color, increased pulse and temperature, urinary frequency, foul-smelling urine, altered mental status, change in behavior or eating patterns. The Physician Order dated 04/30/24, directed staff to administer cephalexin (an antibiotic) 500 milligrams (mg) every morning for UTI prophylaxis (preventative in nature). R16's urinalysis and culture report on 07/11/25 and 12/08/25 resulted in no growth at 48 hours. The urinalysis on 01/18/26 indicated no culture was indicated. R16 remained on cephalexin. The EMR lacked documentation from the practitioner regarding the ongoing use of an antibiotic. On 04/15/26 at 09:05 AM, R16 sat in her room in her recliner with a walker in front of her. She reported feeling well. On 04/15/26 at 10:08 AM, Certified Nurse Aide (CNA) N reported R16 exhibited increased confusion when she had a UTI. CNA N reported R16 was independent with toileting tasks, but checked on her when possible, for changes in R16's urine or behaviors. On 04/15/26 at 11:30 AM, Administrative Nurse D verified that R16 was on prophylactic antibiotics, with no laboratory values to support infection or antibiotic use. The updated facility Unnecessary Drugs policy documented that the indication for initiating, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintaining, or discontinuing medication(s) is determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms to identify and rule out any underlying medical conditions, including assessments of benefits and risks, and the preferences and goals for treatment. The resident's medical record should include documentation of this evaluation and the rationale for the chosen treatment options. - R35's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), and hypertensive chronic kidney disease (a condition where long-term, poorly managed high blood pressure caused chronic renal damage). The Annual Minimum Data Set (MDS) dated [DATE], documented R35 had long and short-term memory problems with severely impaired decision-making skills. R35 was dependent upon staff for toileting, showers, personal hygiene, mobility, and transfers. R35 did not receive any high-risk medications. R35's 04/07/26 Care Plan included the following interventions: 04/15/25 – Administer antihypertensive medications as ordered and monitor for side effects and effectiveness, monitor and report as indicated for headaches, visual problems, monitor laboratory results as ordered from the physician, check his blood pressure four times a day, and notify the physician if the systolic blood pressure (SBP-top number, he force your heart exerts on the walls of your arteries each time it beats) was greater than 160/90 millimeters (mm) of mercury (Hg), heart rate (beats) number of times the heart contracts)beats) per minute (bpm) of greater than 90 bpm or less than 50 bpm. R35's Orders tab of the EMR documented an active order dated 04/15/25 for staff to notify the physician if his SBP was greater than 160 mmHg or less than 90 mmHg, pulse greater than 100 bmp or less than 50 bpm. The orders further directed staff to administer amlodipine, 2.5 milligrams (mg), by mouth, in the morning, for the diagnosis of hypertensive chronic kidney disease. The Vital Signs Record, for February 2026, lacked documentation of blood pressure readings for R35. The EMR recorded R35 was administered his amlodipine daily and lacked documentation that a blood pressure was taken. The Vital Signs Record, for March 2026, documented one blood pressure reading because the resident had a fall. The EMR recorded R35 was administered his amlodipine daily and lacked documentation that a blood pressure was taken. The Vital Signs Record for April 2026 lacked documentation of blood pressure readings for R35. The EMR recorded R35 was administered his amlodipine daily and lacked documentation that a blood pressure was taken. On 04/14/26 at 08:02 AM, R35 sat in the dining room eating his breakfast. On 04/14/26 at 01:45 AM, Licensed Nurse (LN) H stated she was not sure why staff were not obtaining his blood pressure regularly, but thought that some residents had been on long-term medication for which they did not take daily blood pressures. On 04/14/26 at 02:45 PM, Administrative Nurse D stated that although the care plan stated four times (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a day for his blood pressure checks, she did not think that was correct, but stated that staff should check his blood pressure at least monthly to make sure the medication was effective. The facility's Unnecessary Drugs policy, undated, documented that each resident's entire drug/medication regimen was managed and monitored to promote or maintain the resident's highest mental, physical, and psychosocial wellbeing free from unnecessary drugs. Information gathered during the initial and ongoing evaluations would be incorporated into the resident's comprehensive care plan that reflected person-centered medication-related goals and parameters for monitoring the resident's condition, including the likely medication effects and potential for adverse consequences.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to display accurate posted nursing staff hours accessible to residents and visitors. Findings included:- During the survey period of 04/13/26 and 04/14/26, observation revealed the facility did not have posted census and direct care nursing staff hours. On 04/14/26 at 01:47 PM, Administrative Nurse D reported that the nursing hour posting had been posted at the entry of the nursing facility. Administrative Nurse D reported that the administrator had been posting the information, and due to the absence of the administrator, the information had not been posted. Administrative Nurse D stated she had the instructions to provide the information in the usual place upon entry into the facility. The undated facility Nurse Staffing Posting Information policy documented the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time.