STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175291	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Great Bend	1560 K 96 Hwy Great Bend, KS 67530

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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 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** The facility had a census of 61 residents. The sample included 17 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure a 14-day stop date or a specified duration with a rationale for Resident (R) 61's ongoing as-needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R61 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications.Findings included:- R61's Electronic Health Record (EHR) revealed diagnoses of 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), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dysphagia (swallowing difficulty).R61's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R61 had severely impaired cognition. The MDS recorded he required extensive assistance from two staff with bed mobility and transfers. The MDS documented R61 received an antianxiety medication during the observation period.R61's Care Plan, dated 04/02/25, recorded R61 required extensive staff assistance with his activities of daily living (ADL) care. R61's Care Plan documented the resident received Ativan (an antianxiety medication) for end-of-life restlessness.R61's Physician's Order, dated 01/30/25, directed the staff to administer lorazepam (Ativan) 1.0 milligram (mg), one tablet as needed for agitation. The order lacked a stop date.R61's EHR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN lorazepam.On 07/28/25 at 07:40 AM, R61 sat in a broad chair at the dining room table. Certified Medication Aide (CMA) R administered the resident's medication, which included lorazepam 1 mg. On 07/27/25 at 11:00 PM, Administrative Nurse D verified R61 received lorazepam PRN, with a physician order date of 01/30/25. Administrative Nurse D verified that the facility failed to obtain the 14-day stop date or a reason for the continued use with the appropriate rationale. The facility's Antipsychotic Medication Use policy, dated July 2022, recorded the residents would not receive medications that were not clinically indicated to treat specific conditions. Diagnosis of a specific condition for which antipsychotic medications was necessary to treat would be based on comprehensive assessment of the resident. Antipsychotic medications would be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-view. Residents would not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific that is documented in the clinical record. PRN orders for antipsychotic medications would not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and document the rationale for continued use. The duration of the PRN order would be indicated in the order.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 61 residents. The sample included 17 residents, with two reviewed for abuse, neglect, or exploitation. Based on observation, interview, and record review, the facility failed to thoroughly investigate in a timely manner the injury of unknown origin to Resident (R) 48, who stated it happened when staff were transferring her.Findings included: - R48's Electronic Medical Record documented diagnoses of a stable burst fracture of two vertebra (bone of the spinal column), chronic respiratory failure, chronic lymphocytic leukemia (a cancer that develops in the bone marrow, where blood cells are produced) in remission, pain, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and dorsalgia (back pain).R48's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS documented R48 was dependent on staff for transfers and had no falls since admission. R48's Fall Care Area Assessment (CAA), dated 07/14/25, stated contributing factors included weakness, reliance on staff for Activities of daily living (ADL), and mobility.R48's Care Plan, dated 07/11/25, directed staff to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The care plan lacked staff direction for transfers and mobility. The 07/16/25 update stated two skin tears on the left lower leg, with a treatment plan and monitoring in place, initiated 07/18/25.The Progress Note, dated 07/16/25 at 05:00 PM, documented Certified Nurse Aides (CNA) were getting R48 up for supper and noted two bruised areas that were bleeding on her left lower leg. The bruised areas with one 2-centimeter (cm) skin tear and one 3 cm skin tear. Staff cleansed the area with wound cleanser, patted dry, and applied steri-strips and a dry dressing. R48 said her leg bumped something during the transfer.The Incident Report, dated 07/16/25, did not include a dated witness statement even though the resident claimed it happened during a transfer. On 07/28/25 at 10:23 AM, R48 laid in bed with the head of the bed elevated and blue pressure relief booties on her feet. R48 stated the pain in her back was better today. On 07/28/25 at 03:28 PM, Administrative Nurse D stated the interdisciplinary team (IDT) reviewed the incident and should have investigated the incident as an injury of unknown origin. She provided an undated witness statement from the CNA who found the skin tears, but no witness statement documenting what happened. On 07/29/25 at 09:05 AM, Administrative Nurse D stated she thought the CNA wrote a statement that she was transferring the resident when her leg bumped the wheelchair, but did not provide that witness statement.The facility's Abuse, Neglect, Exploitation policy, dated 10/2023, stated all reports of resident abuse (including injuries of unknown origin), neglect, and exploitation were to be reported to local, state, and federal agencies and thoroughly investigated by facility management. The findings of all investigations would be documented and reported. All allegations would be thoroughly investigated. the administrator-initiated investigations. Upon conclusion of the investigation, the investigator records the findings on approved documentation forms.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 61 residents. The sample included 17 residents, with three reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to notify the Office of the Long-Term Care Ombudsman (LTCO - a public official who works to resolve resident issues in nursing facilities) for two sampled residents, Resident (R) 42 and R6. This placed the residents at risk for uninformed care choices. Findings include:- The Electronic Medical Record (EMR) for R42 documented diagnoses of displaced fracture of the base of the neck of the left femur (a break in the left thigh bone), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), 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 inulin) type two. The admission Minimum Data Set (MDS), dated [DATE], documented R42 had moderately impaired cognition. R42 was independent with toileting hygiene, dressing, personal hygiene, mobility, transfers, and ambulation. The MDS further documented R42 had no functional impairment and had no falls. The Quarterly/Five Day Medicare MDS, dated [DATE], documented R42 had intact cognition. R42 required substantial staff assistance for transfers and showers. R42 required partial staff assistance for dressing, personal hygiene, and mobility. The MDS further documented R42 had lower functional impairment on one side, a fall with a major injury, and did not ambulate. R42's Care Plan dated [DATE], initiated on [DATE], directed staff to be sure his call light was within reach and encouraged him to use it for assistance as needed. The care plan directed staff to ensure R42 wore appropriate footwear when ambulating or mobilizing in his wheelchair. R42's Progress Note, dated [DATE] at 02:23 PM, documented R42 was admitted to the hospital with a fracture of the left femur. R42's clinical record lacked evidence that the Ombudsman was notified of the hospital transfer. R42's Progress Note, dated [DATE] at 04:24 PM, documented R42 was readmitted back into the facility. On [DATE] at 09:23 AM, R42 sat in his recliner, hair disheveled, greasy, and unshaven. R42 stated he had no pain and was independent with transfers and ambulation. On [DATE] at 01:30 PM, Social Service X stated the Ombudsman had not been notified of the hospital transfer, R42 had been mistakenly missed when the notice to the Ombudsman was sent at the end of June. On [DATE] at 08:53 AM, Administrative Nurse D stated the Ombudsman should be notified when a resident is transferred to the hospital. (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 Transfer or Discharge Notices policy, dated 03/25, documented residents or resident representatives were notified of an impending transfer or discharge in writing and a language and manner they would understand. A copy of the notice was sent to the Office of the State Long-Term Care Ombudsman. - R6's Electronic Health Record (EHR) revealed diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), chronic kidney disease (longstanding disease of the kidneys leading to renal failure) with behavioral disturbance, encephalopathy (inflammatory condition of the brain), and acute bronchitis (inflammation of the lining of bronchial tubes which carry air to and from the lungs). R'6s Quarterly Minimum Data Set (MDS), dated [DATE], recorded R6 had severe cognitive impairment (problems with thinking, learning, remembering, and using judgment). The MDS recorded she required staff assistance with transfers and activities of daily living (ADL). The MDS documented the resident had occasional incontinence and ambulated with a wheelchair. The Care Area Assessment (CAA), dated [DATE], recorded R6 required staff assistance with ADLs due to impaired functional ability. The CAA documented the resident had incontinence of urine with a diagnosis of chronic kidney disease and required assistance with toileting, transfers, and hygiene. R6's Care Plan, dated [DATE], recorded R6 required staff assistance with most ADL care. R6's Care Plan documented the resident required staff assistance with incontinent cares and assistance. The care plan documented staff were to allow the resident privacy when using the restroom; however, stay near the bathroom and ready to provide assistance when R6 required it. The care plan documented R6 had the potential for falls related to needing assistance with ADL's and staff would encourage her to call for assistance when needed. On [DATE] at 08:56 AM, Nurse's Notes documented R6 had a wet cough, warm to the touch, and had had confusion. The note documented R6 was in bed and had been incontinent and needed more assistance with cares. The resident's vital signs were temperature 100.7 (normal 97.9to 98.6), blood pressure 134/99 (normal 120/80), pulse 101 (normal 60-100), respirations 20 (normal 12-20), and oxygen saturation was 96 percent (normal 95-100). On [DATE] at 04:21 PM, Nurses Notes documented R6 had been shaky, with clammy skin, yellowish looking skin, and had not been making very good words with talking today. The notes documented R6 had been incontinent, weak, not eating much, with a moist wet cough, her blood sugar reading was 105 (normal 70-99), the facility called her primary care physician, and sent the res to the emergency room by ambulance to be treated and evaluated. The primary care physician ordered the resident to be sent to the hospital. The notes documented R6 left with EMS at 04:20 PM. R6's niece was contacted with the information. On [DATE] at 04:37 AM, Nurse's Notes documented the facility received an admission history and physical from the primary care physician for R6's admission to the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 04:16 PM, Nurse's Notes documented the resident was admitted back to the facility with a diagnosis of acute metabolic encephalopathy hypoxia, urinary tract infection, and rhinovirus. The resident was transported from the transport van to the facility in a wheelchair. The resident had a foley catheter and had oxygen per nasal cannula set at 2 liters continuous flow. The resident was admitted on antibiotics for lower respiratory infection for seven days and had a non-productive cough. R6's clinical record lacked documentation staff notified the LTCO of R6's discharge from the facility. On [DATE] at 10:40 AM, Social Service X stated she would send notification of discharge to the Ombudsman regarding the resident's discharge from the facility to home, hospital, and if they had expired, once a month. Social Service X verified she failed to include R6 in the [DATE] discharges. On [DATE] at 09:30 AM, Administrative Nurse D verified that the social service designee would send monthly reports to the Ombudsman office that included residents who were discharged , went to the hospital, and expired residents from the facility. Administrative Nurse D verified SSD X notified her she failed to include R6 in the [DATE] report to the Ombudsman office. The facility's Transfer or Discharge Notice policy dated [DATE] documented residents or residents' representatives are notified of an impending transfer or discharge and the reason for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the Ombudsman. A copy is sent to the Office of the State Long Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. The facility will send a copy of the discharge notice to the Office of the State Long Term Care Ombudsman. Notice to the Office of the State LTC Ombudsman will occur at the same time as the notice of discharge is provided to the resident and the resident's representative.

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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. (continued on next page)

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F 0677 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 had a census of 61 residents. The sample included 17 residents, with three reviewed for bathing. Based on observation, record review, and interview, the facility failed to provide consistent bathing services for two residents, Resident (R) 27 and R42. This placed the residents at risk for complications related to poor hygiene.Findings included:- The Electronic Medical Record (EMR) for R27 documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of his fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).The Annual Minimum Data Set (MDS), dated [DATE], documented R27 had intact cognition. R27 was independent with eating, toileting hygiene, dressing, personal hygiene, mobility, and transfers. R27 required supervision with ambulation and bathing.R27's Care Plan, dated 05/19/25, initiated on 04/18/24, documented R27 preferred three baths per week and required staff assistance.The May 2025 Bathing Sheets documented R27 had not received a bath or shower during the following days:05/05/25 - 05/17/25 (13 days)05/19/25 - 05/29/25 (11 days)The EMR documented R27 refused bathing on 05/07/25, 05/08/25, 05/11/25, and 05/14/25.The June 2025 Bathing Sheets documented R27 had not received a bath or shower during the following days:06/01/25 - 06/19/25 (19 days)06/21/25 - 06/30/25 (10 days)The EMR documented R27 refused bathing on 06/01/25, 06/06/25, 06/08/25, 06/11/25, 06/22/25, 06/25/25, and 06/29/25.The July 2025 Bathing Sheets documented R27 had not received a bath or shower during the following days:07/21/25 - 07/28/25 (8 days)The EMR documented R27 refused her bathing on 07/23/25.On 07/28/25 at 12:30 PM, R27 sat at the dining room table, hair uncombed. When R27 was asked any questions, she would not respond.On 07/29/25 at 09:10 AM, Licensed Nurse H stated R27 refused bathing. Staff offered alternative days and times, but R27 would continue to refuse.On 09/29/25 at 09:20 AM, Certified Nurse Aide (CNA) N stated R27 usually took her showers if she was working but would often refuse other staff. If a resident refused, they would tell the nurse, and the nurse would talk with the resident. CNA N further stated res are offered alternative bathing dates or times.On 07/29/25 at 09:53 AM, Administrative Nurse D stated residents who refused bathing were offered a different option, such as bed baths or provided with a wash rag. The CNA would chart on the bath sheet that the resident refused, and then the nurse was notified so the nurse could talk with the resident.The facility Shower/Tub Bath policy, dated 10/10, documented that the facility promoted cleanliness and provided comfort to the resident. Staff were to observe the condition of the resident's skin and notify the supervisor if the resident refused the shower or bath. The physician was notified if the resident had any areas that may need to be treated. Staff are to report other information according to facility policy and professional standards of practice.- The Electronic Medical Record (EMR) for R42 documented diagnoses of displaced fracture of the base of the neck of the left femur (a break in the left thigh bone), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure, 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 inulin) type two.The admission Minimum Data Set (MDS), dated [DATE], documented R42 had moderately impaired cognition. R42 was independent with toileting hygiene, dressing, personal hygiene, mobility, transfers, and ambulation. R42 received partial assistance with bathing.The Quarterly/Five Day Medicare MDS, dated 06/27/25, documented R42 had an intact condition. R42 required substantial staff assistance for transfers and showers. R42 required partial staff assistance for dressing, personal hygiene, and mobility.R42's Care Plan, dated 06/29/25, initiated on 04/11/25, documented R42 required partial to moderate assistance with bathing. R42 required cueing and reminders to complete self-care and hygiene tasks.The May, June, and July 2025 Bathing Sheets documented R42 had not received a shower on the following days:05/06/25 - 06/08/24 (34 days)06/10/25 - 06/19/25 (10 days)R42 was hospitalized from [DATE] - 06/25/2506/25/25 - 07/13/25 (19 days)07/15/25 -07/28/25 (14 days)The EMR documented R42 refused bathing on 05/19/25, 05/27/25, 06/09,25, 06/16/25, 06/30/25, 07/07/25, and 07/21/25.On 07/28/25 at 09:23 AM, R42 sat in his chair in his room. His hair was uncombed, greasy, and he was unshaven. R42 had on yellow socks; both socks were very soiled with a dried substance all over the socks. R42 stated he did not know what was all over his socks. When R42 was asked about his bathing and if staff offered different choices, he stated, I don't know. On 07/29/25 at 09:10 AM, Licensed Nurse H stated R42 refused bathing

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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. The facility had a census of 61 residents. The sample included 17 residents, with one reviewed for range of motion (ROM). Based on observation, interview, and record review, the facility failed to provide ROM services to improve or maintain Resident (R) 56's ROM in his partially contracted (abnormal permanent fixation of a joint or muscle) right hand.Findings included:- R56‘s Electronic Medical Record documented a diagnosis of hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke) affecting his right dominant side.R56‘s Minimum Data Set (MDS), dated 05/26/25, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R56 required moderate staff assistance for mobility and dressing, and did not receive splint or brace therapy or restorative services.R56‘s Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 02/27/25, documented he required assistance with ADL's due to hemiplegia and generalized weakness. R56‘s Care Plan, dated 05/19/25, lacked interventions related to the prevention of contractures. The care plan stated R56 had limited physical mobility related to hemiplegia from a cerebral vascular accident affecting his right dominant side. Staff were to monitor, document, and report any signs of immobility, such as contractures forming or worsening, initiated 03/11/25. The care plan stated R56 would receive appropriate specialized services to attain or maintain his highest practicable psychological, physical, functional, and psychosocial well-being, initiated 03/16/24. The Physician Order, dated 02/28/24, directed staff to perform brace skin care, check skin covered by the brace every shift, and report any changes to the physician.On 07/27/25 at 09:32 AM, R56 sat in his recliner in his room. R56 stated he had a stroke with right sided paralysis. R56's hand was in a fist without a splint (it was on his bed, out of reach). He stated he required assistance to place the splint. R56 stated staff did not provide ROM for his right hand or any other restorative exercises. On 07/28/25 at 09:45 AM, Licensed Nurse (LN) H stated the facility did not have restorative aides. She stated they used to, but the aides were usually busy doing regular aide work. She did not know if R56 was supposed to have the hand splint on. LN H entered his room and asked him if he wanted to wear the splint and offered to put it on if he put it out every morning. LN H then placed one of the two braces he had in his room on his right hand/wrist. On 07/28/25 at 10:00 AM, Administrative Nurse E stated the facility had not had a restorative program for the past few years. She verified that the care plan did not include interventions to prevent contractures.On 07/28/25 at 10:06 AM, Therapy Consultant GG stated R56's right hand did not open to full extension. He was admitted with a splint, and the facility got him a softer splint after he complained about the original one. Therapy Consultant GG stated he was educated on donning/doffing a splint and said he could do it himself. He was to use it for two to five hours as tolerated.On 07/29/25 at 09:00 AM, Administrative Nurse D verified that the facility should provide restorative services to maintain or improve residents' range of motion. The facility's Restorative Nursing Services policy, dated 07/2022, stated residents would receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of their stay, or when discharged from rehabilitative care.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** The facility had a census of 61 residents. The sample included 17 residents, with nine reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure staff provided adequate supervision to prevent the elopement of Cognitively Impaired Resident (R) 37, who was at risk for wandering/elopement, falls, and used a walker for mobility. The facility also failed to conduct a complete investigation when R48 obtained skin tears of unknown origin. This placed the resident at risk for abuse.On 07/15/25 at approximately 07:35 PM, facility staff could not find R37 in the building and reported seeing R37 in the lobby approximately 5-10 minutes prior. The staff found R37's walker in the lobby, but not R37. The staff located R37 outside in the facility van, seated in the front seat, in approximately 95-degree Fahrenheit (F) weather. The facility did not know how R37 got outside without staff knowledge. The failure to prevent a cognitively impaired resident from exiting the facility without staff supervision or knowledge and entering an unsafe location placed R37 in immediate jeopardy and other wandering residents at risk.Findings included:- R37 Electronic Medical Record (EMR) documented R37 had diagnoses, which included: a history of falling and dementia (a progressive mental disorder characterized by failing memory and confusion). R37's admission Minimum Data Assessment (MDS), dated [DATE], documented R37 had a Brief Interview of Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The MDS documented R37 used a walker for mobility and required staff supervision with ambulation. The MDS documented R37 had a fall in the last two to six months. R37's Care Area Assessment(CAA), dated 11/07/24, documented the CAA triggered due to R37 was at risk for falls. R37's risk for falls included: generalized weakness, decreased safety awareness, a history of falls before admission, and psychotropic (alters mood or thought) medications. The CAA documented R37 had a BIMS of three and a diagnosis of dementia. R37's Quarterly MDS, dated 05/28/25, documented R37 had a BIMS score of five, which indicated severe cognitive impairment. R37 used a walker for mobility and required supervision with ambulation. The MDS documented R37 had no falls since the prior assessment. R37's Care Plan, revised 05/31/25, documented R37 had limited physical mobility and instructed staff to provide R37 with one staff assistance, using a walker for ambulation. The plan lacked interventions regarding R37's elopement risk. The plan documented R37 had impaired cognitive function related to dementia and instructed staff to cue, reorient, and supervise her as needed. The plan documented R37 as at risk for falls, instructed staff to anticipate and meet the resident's needs, and offer and assist R37 with ambulation. The Elopement Evaluation dated 11/05/24 documented R37 with a history of elopement or attempted elopement while at home and wandering behavior. The Elopement Evaluation dated 05/31/25 lacked documentation regarding whether R37 had a history of elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/15/25 at approximately 07:35 PM, facility staff could not find R37 in the building and reported seeing R37 in the lobby approximately 5-10 minutes prior. The staff found R37's walker in the lobby, but not R37, and reported that the door alarm did not activate. The staff located R37 outside of the building, in the facility van, and seated in the front seat in approximately 95 degrees Fahrenheit (F) weather. The facility did not know how R37 got outside without their knowledge. The National Weather Service table titled Temperature Inside a Vehicle noted an ambient temperature outside of 93 degrees F, the temperature inside a vehicle can rise up to 130 degrees F within 60 minutes. According to Weather Underground, the weather outside at the time R37 left the building, unsupervised, was approximately 95 degrees Fahrenheit and sunny. The staff found R37 in the front seat of the facility van. Observation revealed the facility is located near a highway, with speed limits of 40 miles per hour (mph), approximately 100 feet from the building. Cognitively impaired R37 is at a fall risk and did not have her walker with her. During a phone interview on 07/27/25 at 09:42 AM, Certified Nurse Aide (CNA) O stated she was working on 07/15/25 when R37 left the building without staff supervision. CNA O stated prior to the elopement, R37 sat in the lobby on the couch by the entrance door. CNA O went down the southwest hall of the facility to answer a couple of call lights, and when she came back, R37 was not on the couch, but her walker was beside it. CNA O started looking for R37 because R37 was known to wander. CNA O stated CNA P went outside looking for R37 and noted the front entrance door was not alarming. On 07/28/25 at 09:06 AM, Administrative Nurse D stated on 07/16/25, the night of R37's elopement, the door alarm was not sounding when staff noticed R37 was missing from inside the facility. Administrative Nurse D stated she did not know how R37 exited the building without staff supervision, but thought R37 might have followed a family member out the door. The facility's Wandering and Elopement Policy, revised 06/17/20, documented if a resident was determined to be at risk for wandering and elopement, educational materials would be available concerning the risk for eloping. Specific intervention(s) would be provided to the resident and family and would be documented in the resident's record. A wandering /elopement risk evaluation, too, would be completed by a licensed member of the clinical staff for each resident to identify the level of risk which may lead to elopement upon admission or readmission, quarterly, upon a change in status or condition as it related to unsafe wandering, post-elopement or elopement attempts, and as required by state regulation. On 07/28/25 at 12:33 PM, Administrative Staff A and Administrative Nurse D were provided the IJ template and notified that the facility's failure to provide safe, adequate supervision for cognitively impaired R37 to prevent the elopement placed the resident in immediate jeopardy. The facility's corrective measures, completed on 07/25/25, included the following: In-service on elopement policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Checked all door alarms Conducted elopement drill, and four drills will be held annually at each community: One drill will be held each shift, including one weekend day. An elopement evaluation tool was completed by a licensed member of the clinical staff for each resident identified as a risk for elopement. In-service for transportation driver regarding the facility van would be locked at all times. The surveyor verified the implemented corrective actions while on site; the deficient practice was deemed past non-compliance and remained at a J scope and severity. - R48's Electronic Medical Record documented diagnoses of a stable burst fracture of two vertebra (bone of the spinal column), chronic respiratory failure, chronic lymphocytic leukemia (a cancer that develops in the bone marrow, where blood cells are produced) in remission, pain, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and dorsalgia (back pain). R48's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate impairment. The MDS documented R48 was dependent on staff for transfers and had no falls since admission. R48's Fall Care Area Assessment (CAA), dated 07/14/25, stated contributing factors include weakness, reliant on staff for Activities of daily living (ADL), and mobility. R48's Care Plan, dated 07/11/25, directed staff to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The care plan laid out staff direction for transfers and mobility. The 07/16/25 update stated two skin tears on the left lower leg, with a treatment plan and monitoring plan, initiated 07/18/25. The Progress Note, dated 07/16/25 at 05:00 PM, documented Certified Nurse Aides (CNA) were getting R48 up for supper and noted two bruised areas that were bleeding on her left lower leg. The bruised areas with one 2 centimeters (cm) skin tear and one 3 cm skin tear. Staff cleansed the area with wound cleanser, patted dry, and applied steri-strips and a dry dressing. R48 said her leg bumped something during the transfer. The Incident Report, dated 07/16/25, did not include a dated witness statement even though the resident claimed it happened during a transfer. On 07/28/25 at 10:23 AM, R48 laid in bed with the head of the bed elevated and blue pressure relief booties on her feet. R48 stated the pain in her back was better today. On 07/28/25 at 03:28 PM, Administrative Nurse D stated the interdisciplinary team (IDT) reviewed the incident. She provided an undated witness statement from the CNA who found the skin tears, but no witness statement documenting what happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/29/25 at 09:05 AM, Administrative Nurse D stated she thought the CNA wrote a statement that she was transferring the resident when her leg bumped the wheelchair but did not provide that witness statement. The facility's Abuse, Neglect, Exploitation policy, dated 10/2023, stated all reports of resident abuse (including injuries of unknown origin), neglect, and exploitation were to be reported to local, state, and federal agencies and thoroughly investigated by facility management. The findings of all investigations would be documented and reported. All allegations would be thoroughly investigated. the administrator initiated investigations. Upon conclusion of the investigation, the investigator records the findings on approved documentation forms.

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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 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 had a census of 61 residents. The sample included 17 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to provide interventions for bowel management for one resident, Resident (R) 9. This placed R9 at risk for physical decline and fecal impaction (accumulation of hardened feces in the rectum that the individual was unable to move).- The Electronic Medical Record for R9 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and constipation (difficulty passing stool).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R9 had moderately impaired cognition. R9 was independent with toileting hygiene, personal hygiene, mobility, transfers, and dressing. R9 was always continent of bladder and bowel and did not have constipation.R9's Care Plan, dated 07/23/25, initiated on 06/28/22, documented R9 had a history of constipation and directed staff to administer medications as ordered. Staff were directed to monitor medications for side effects of constipation and keep the physician informed of any problems. The care plan further directed staff to report to the physician any changes in bowel patterns and record the bowel movement pattern each day.The Standing Orders, dated 12/01/23, for R9 directed staff to administer Milk of Magnesium (MOM), 30 milliliters (ml), as needed for up to twice daily or Dulcolax suppository (inserted into the rectum), one daily, as needed for constipation. Notify the physician if no results after two doses of MOM with a full bowel assessment.The Physician's Order, dated 04/15/25, directed staff to administer DOK (docusate sodium-a stool softener), 100 milligrams (mg), two capsules, daily, for constipation.R9's Bowel Monitoring Record, dated June and July 2025, documented R9 did not have a bowel movement for the following days:06/30/25 - 07/07/25 (8 consecutive days)R9's Medication Administration Record (MAR) for June and July 2025 lacked documentation of the staff providing interventions during the lack of bowel elimination on the above dates.The EMR lacked documentation that a bowel assessment was completed for the dates of 06/30/25 to 07/07/25.On 07/28/25 at 12:15 PM, R9 left the dining room table in his wheelchair to go to the bathroom.On 07/29/25 at 09:00 AM, Licensed Nurse (LN) H stated night shift received a report for the residents who had not had a bowel movement for three days, and notified Administrative Nurse D of any resident who had not had a bowel movement in three days, and standing orders were started.On 07/29/25 at 09:18 AM, Certified Nurse Aide (CNA) N stated R9 told the staff when he had a bowel movement and to document it in the computer.On 07/29/25 at 09:53 AM, Administrative Nurse D stated that there are standing orders for residents who have not had a bowel movement after three days, and bowel sounds are assessed. The facility's Bowel (Lower Gastrointestinal (GI) Tract) Disorders policy, dated 09/17, documented that as part of the initial assessment, the staff and physician would help identify individuals with previously identified lower GI tract conditions and symptoms. The staff and physician would identify risk factors related to bowel dysfunction. The staff would check for diffuse or localized tenderness and listen for bowel sounds. The physician would identify and order pertinent cause-specific and symptomatic interventions to institute a regimen to prevent constipation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. The facility had a census of 61 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 11's medication administration was free from significant errors when staff crushed one extended-release medication. This placed R11 at risk for the medication being improperly released.Fincings included:- On 07/28/25 at 08:52 AM, Certified Medication Aide (CMA) R crushed medications for R11, including metoprolol (medication used to treat chest pain (angina), heart failure, and high blood pressure) extended release (ER), 25 milligrams (mg). CMA R placed the crushed medications in applesauce and administered them to R11, even after being asked if it was okay to crush metoprolol ER. CMA R stated she would ask the nurse later. On 07/28/25 at 11:25 AM, Administrative Nurse E verified R11's metoprolol pill card stated ER Do not crush. Administrative Nurse E verified the physician order of 06/13/25 was not metoprolol ER, but the earlier 06/11/25 re-admission orders had been for ER metoprolol. Administrative Nurse E verified the 06/13/25 order was currently in effect. On 07/28/25 at 11:32 AM, LN H contacted the pharmacy regarding the order and stated she would fax the latest order to them. On 07/29/25 at 09:09 AM, Administrative Nurse D verified that nursing should have notified the pharmacy of the change in the metoprolol order in a timely manner and ensured the Medication Administration Record (MAR) was correct. The facility's Administering Medications policy, dated 06/2022, stated medications are administered in accordance with prescriber orders. The individual administering the medication would check the label to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 61 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to label Resident (R)5 and R69s' insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened for use and when expired. This deficient practice placed the affected residents at risk for ineffective medications. The facility failed to ensure medications were only accessible to licensed staff when the treatment cart was left unlocked without licensed staff supervision. Findings included: - On [DATE] at 11:38 AM, the Northeast Hall nurse treatment cart was found in the hall, unlocked with insulin and other medication accessible to anyone. At that time, no staff were in sight of the treatment cart. Licensed Nurse (LN) G was located in a resident room, out of sight of the cart. When LN G came out of the resident's room, she verified that she should have locked the cart. On [DATE] at 09:05 AM, Administrative Nurse D verified that staff should not leave the treatment cart unlocked when out of sight of licensed staff. The facility's Administering Medications policy, dated 06/2022, stated during the administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. - On [DATE] at 08:45 AM, observation of R5's Lantus (long-acting insulin) flex pen was labeled with a date opened [DATE] and an expired date of [DATE] (46 days outdated) and still in use. Observation of R69's Mounjaro (Long-acting medication) lacked a date opened or a date expired. On [DATE] at 08:50 AM, License Nurse G verified that the nurses should label and date the insulin flex pens with the date opened and should discard expired insulin flex pens. On [DATE] at 09:20 AM, Administrative Nurse D verified that the nurse should label and date the insulin flex pens with the date opened and discard expired insulin flex pens. Medlineplus.gov directs open, unrefrigerated Lantus can be used within 28 days; after that time, they must be discarded. Moujaro should be used within 30 days; after that time, it should be discarded. The facility's Storage of Medications policy, dated [DATE], documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs containers that have missing, incomplete, or incorrect labels are returned to the pharmacy for proper labeling before storing, discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 62 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full-time certified dietary manager for the 61 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition.Findings included:- On 07/27/25 at 08:45 AM, observation revealed that dietary staff in the kitchen prepared the breakfast meal. On 07/27/25 at 12:00 PM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated the facility had three residents with a pureed diet and 15 with a mechanical soft diet. On 07/29/25 at 09:15 AM, Administrative Nurse D verified Dietary Staff BB was not certified.Upon request, the facility lacked a Certified Dietary Manager policy.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 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 had a census of 61 residents. The sample included 17 residents, with one reviewed for hospice (a type of health care that focused on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 6. This placed the residents at risk for inadequate end-of-life cares. Findings included:- R6's Electronic Health Record (EHR) revealed diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), chronic kidney disease (longstanding disease of the kidneys leading to renal failure) with behavioral disturbance, encephalopathy (inflammatory condition of the brain), acute bronchitis (inflammation of the lining of bronchial tubes which carry air to and from the lungs), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).R6's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R6 had severe cognitive impairment (problems with thinking, learning, remembering, and using judgment). The MDS recorded she required staff assistance with transfers and activities of daily living (ADL). The MDS documented the resident had occasional incontinence and ambulated with a wheelchair. The MDS did not document the resident received hospice service due to the fact it was ordered on 07/16/25.The Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 09/27/24, recorded R6 required staff assistance with ADLs due to impaired functional ability. The CAA documented the resident had incontinence of urine with a diagnosis of chronic kidney disease and required assistance with toileting, transfers, and hygiene. R6s Care Plan, dated 04/23/25, recorded R6 required staff assistance with most ADL care. R6's Care Plan documented the resident required staff assistance with incontinent cares and assistance. The care plan documented staff were to allow the resident privacy when using the restroom; however, stay near the bathroom and ready to provide assistance when R6 required it. The care plan documented R6 had the potential for falls related to needing assistance with ADL's and staff would encourage her to call for assistance when needed. The Nurse's Notes, dated 07/14/25 at 11:14 AM, documented the facility received orders from the primary care physician to consult hospice care and discontinue skilled therapy. R6's Physician Order dated 07/16/25, documented the resident would receive hospice services. Review of R6's clinical record revealed the resident was admitted to hospice care on 07/14/25 with a diagnosis of congestive heart failure, chronic kidney disease Stage 3, and Alzheimer's. The facility had a care plan provided by hospice in the electronic health records. On 07/27/25 at 11:50 AM, R6 was dressed in street clothes in a wheelchair at the dining room table with oxygen on per nasal cannula, eating lunch.On 07/27/25 at 12:25 PM, Administrative Nurse D verified the facility lacked a facility care plan that indicated R6 was on hospice services.The facility's Care Plans, Comprehensive policy, dated March 2022, documented a comprehensive person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan included measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being which included services that would otherwise be provided but are not provided due t the resident exercising his or her rights, including the right to refuse treatment.=, any specialized services to be provided as a result of the PASARR recommendations, which professional services are responsible for each element of care. This included the resident's stated goals upon admission and desired outcomes, building on strengths and reflecting on currently recognized standards of practice for problem areas and conditions. Assessments were outgoing, and care plans were revised as information about the residents in the resident conditions changed. The ID team reviewed and updated the care plan when there has been a significant change in the resident's condition, when the desired outcome was not met, when the resident has been admitted /readmitted to the facility from a hospital stay, and at least quarterly, and in conjunction with the required quarterly assessment.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 61 residents. The sample included 17 residents. Based on record review and interview, the facility failed to submit complete and accurate staffing information through the Payroll-Based Journal (PBJ) as required. This deficient practice placed the residents a risk for inadequate staffing.Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for fiscal Year (FY) 2025, Quarter (Q) 1 and FY 2025 Q 2 indicated excessively low weekend staffing.Review of the facility's Nursing staffing schedule for the above quarter revealed adequate staff on duty was provided.On 07/28/25 at 01:39 PM, Administrative Nurse D stated that the daily schedule sheets with updates are sent to the regional office. If there were any changes to the schedule, they would also be sent with the updates to the regional office.The facility's Reporting Direct Care Staffing Information (Payroll-Based Journal) policy, dated 08/22, documented that direct staffing information was reported to CMS electronically through the payroll-based journal system. Complete and accurate direct care information was reported in a uniform format specified by CMS. The staffing information was collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. The data was submitted only by designated personnel with training on the PBJ user interface.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 61 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to ensure staff used Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact cares) when providing care with close contact to residents with an open wound or an indwelling device and failed to properly disinfect a blood glucose meter used for more than one resident. This deficient practice placed all residents at risk for infection.Findings included:- On 07/27/25 at 12:28 PM, Licensed Nurse (LN) G obtained a blood sugar (BS) reading with a facility glucometer for Resident (R) 31. LN G did not clean or disinfect the glucometer before putting it away in the drawer on top of the other glucometer. On 07/28/25 at 09:05 AM, observation revealed a sign on R11's door directing staff to use EBP during cares. On 07/28/25 at 09:05 AM, Certified Nurse Aide (CNA) M and CNA N used a total mechanical lift to transfer R11 from her wheelchair to her bed. The CNAs did not don EBP gowns before providing incontinence cares. R11 had a dressing with drainage on her right buttock. At 09:20 AM, LN H performed wound care for R11 and did not don an EBP gown. R11's right buttock had an irregular shaped open wound and another open wound to her coccyx area. On 07/28/25 at 09:20 AM, LN H stated EBP was used when R11 had a foot wound before amputation. She stated that staff no longer used the EBP for this resident. On 07/28/25 at 09:54 AM, Administrative Nurse E stated EBP should be worn during cares for any resident with an open wound. On 07/28/25 at 12:50 PM, Administrative Nurse E verified staff were to disinfect the glucometer after each use. The facility had two glucometers used for seven residents on the north halls. The Assure Prism BG monitoring system (blood glucose meter) instruction manual stated the meter should be cleaned and disinfected after use on each patient. The BG system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures were followed. The manufacturer validated Clorox Healthcare Bleach Germicidal wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, CaviWipes 1, and PDI Super Sani Cloth Germicidal disposable wipes used for disinfecting the Assure Prism multi-meter. Allow the disinfectant to stay wet for 1-2 minutes. The facility's Cleaning and Disinfection of Resident Care Items policy, dated 10/2023, stated resident care equipment, including reusable items and durable medical equipment, would be cleaned and disinfected between residents per current Centers for Disease Control (CDC) recommendations for disinfection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175291	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Great Bend	1560 K 96 Hwy Great Bend, KS 67530

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Enhanced Barrier Precautions policy, dated 04/2024, stated EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care. Examples of high contact resident care requiring the use of a gown and gloves for EBP included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care, and wound care for pressure ulcers, diabetic ulcers, surgical wounds, and venous stasis ulcers. - R2's Electronic Medical Record (EMR) documented that R2 had a diagnoses of acquired absence of kidney (one of a pair of organs in the abdomen), chronic kidney disease (a condition where the kidneys are damaged and can't filter blood effectively, leading to a buildup of waste and other problems), and benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections). R2's Medicare Five Day Minimum Data Set (MDS), dated [DATE], documented that R2 had a Brief Interview of Mental Status (BIMS) of 13, which indicated intact cognition. The MDS documented R2 had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). R2's Care Plan, revised 05/20/25, documented R2 dependent on staff assistance with toileting. The plan instructed staff to provide R2 catheter care every shift, monitor and document intake and output as per facility policy. The plan documented R2 was on EBP related to his urinary catheter and instructed staff to use appropriate personal protective equipment (PPE). On 07/27/25 at 03:37 PM, R2 sat in a recliner in his room with the door open. Certified Nurse Aide (CNA) Q entered the room, went into R2's bathroom, retrieved a graduated cylinder, then, without gloves or gown, emptied R2's urine from his catheter into the graduated cylinder. CNA Q took the urine-filled graduated cylinder to the bathroom and emptied it into the toilet, rinsed it out using water from the sink, and poured the water into the toilet. When CNA Q was asked what the EBP sign posted beside R2's room entrance door, she stated that staff have to place gloves and a gown on when providing catheter care. CNA Q verified she had not applied gloves or a gown when emptying R2's urinary catheter bag and stated she should have. On 07/29/25 at 09:57 AM, Administrative Nurse D stated if a resident is on EBP, staff should place a gown and gloves on before providing any catheter care. The facility's EBP policy, dated 04/2024, documented EBPs are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident are activities that provide opportunities for transfer of Multidrug-Resistant Organism (MDRO- standard medications used to treat infections caused by these organisms are ineffective, making infections difficult to treat.)to staff hands and clothing. Gloves and a gown are applied before performing the high-contact resident care activity (as opposed to before entering the room). PPE is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high contact resident care activities requiring the use of a gown and gloves for EBP's include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, or device care of use (urinary catheter, etc.). Wound care (wounds generally include chronic wounds, not shorter-lasting wounds, such as skin tears or skin grafts covered with an adhesive bandage or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.