STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175304	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Presbyterian Manor	2300 Industrial Road Emporia, KS 66801

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 51. The sample included 14 residents. Based on record review, interview, and observation revealed the facility failed to provide care for Resident (R)11 and R19 in a manner that protected and promoted their dignity. Findings included:- On 03/02/26 at 12:10 PM, observation revealed R11 sat in a chair at the dining room table. Licensed Nurse (LN) G obtained R11's blood sugar reading using a glucometer (an instrument used to calculate blood glucose) from R11's right fourth finger. Continued observation revealed six residents were seated at the dining room awaiting lunch to be served, while other residents were seated in adjacent tables in the dining room, including one visitor and staff. On 03/02/26 at 12:20 PM, R11 got up from the dining room table, walked to her room, and laid down. Observation revealed she had see-through, thin material pink pants and her brief was visible through the pants. On 03/03/26 at 07:45 AM, R11 walked to the dining room table and sat down for breakfast. Observation revealed R11 had the same see through pant on she wore the day before and her briefs were visible through the pants. On 03/04/26 at 10:20 AM, Administrative Nurse D verified the nurse should not do blood sugar at the dining room table and R11 should not have pants on that are see through due to dignity concerns. The facility's Residents Dignity policy, dated 02/03/25, documented the facility would ensure the residents' right to dignified existence, self-determination and person-centered care with access to people and services inside and outside the community. The community would protect and promote the rights of each resident. The community would treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of his/her quality of life, recognizing each resident's individuality. The community would provide equal access to quality care regardless of diagnosis, severity, condition, or payment source. The community would support the resident in the exercise of his or her rights. The community would ensure residents can exercise his/her rights without interference, coercion, discrimination or reprisal. - R19's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of paraparesis (partial paralysis, usually affecting only the lower extremities), major depressive disorder (major mood disorder that causes persistent feelings of sadness), disorders of teeth and supporting structures, dysphagia (swallowing difficulty), and contracture (abnormal permanent fixation of a joint or muscle). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) (continued on next page)

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	score of 14 which indicated intact cognition. The MDS documented R19 had an impairment of both sides of his upper and lower body. The MDS documented R19 was dependent on staff for all activities of daily living (ADLs) except eating R19 needed supervising and touching assistance. R19's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 02/04/26 documented impaired mobility self-care deficit related to paraplegia and polyneuropathy (a condition that affects multiple peripheral nerves in the body, affecting sensation and movement). R19's Care Plan documented the following: 04/28/25-Setup assistance with adaptive equipment and supervision assistance with meals. 05/29/25-Half portions at meals to lose weight. 11/12/25-Mechanicl soft consistency. 02/04/26-Supervision to partial assistance with meals On 03/02/26 at 9:15 AM, Certified Nurse's Aide (CNA)M stood by R19's right side and assisted him with eating a bite of bacon. On 03/04/26 at 08:11 AM, CNA O stated staff have all been in serviced to sit next to the resident the CNA was helping. She stated nursing staff were never to stand over a resident to assist the resident with eating. On 03/04/26 at 08:35, Licensed Nurse (LN) I stated she was unsure how staff should be positioned when assisting residents with eating. LN I stated she had seen staff stand and sit. 03/04/26 at 08:04 Administrative Nurse D stated staff have been in serviced to sit in a chair, and converse with the resident the staff were assisting. The facility's Resident Rights and Responsibility's policy dated 02/25 documented the community would ensure the residents' right to a dignified existence, self-determination and person-centered care with access to person and services inside and outside the community. The community would protect and promote the rights of each resident. The community would treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 51 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure reasonable accommodation of needs when staff failed to ensure Resident (R)8's call light was within his reach.Findings included:- R8's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), unsteadiness on feet, muscle weakness, and repeated falls.The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R8 was dependent on staff for toileting and needed supervision or touching assistance from staff with eating.The Falls Care Area Assessment (CAA) dated 01/22/26 documented R8 was at risk for falls related to a history of falls, impaired mobility, weakness, dementia, urinary catheter, and required assistance with transfers/mobility.R8's Care Plan documented the following:01/28/26- R8 had been instructed to use call light for assistance.01/28/26- R8 was dependent on one or two staff for toileting throughout the day to manage bowel incontinence.On 03/03/26 at 10:20 AM, R8 sat in his room in front of the TV in his Broda chair (specialized wheelchair with the ability to tilt and recline). R8's pancake light laid in the middle of his bed. R8 could not reach his call light to call for assistance.On 03/03/26 at 10:21 AM, Certified Nursing Aide (CNA) N stated R8's call light was out of reach. CNA N stated R8's call light should be where he could reach the light and use the light. CNA N placed R8's light next to him on his bedside table, within his reach.On 03/04/26 at 08:34 AM, Licensed Nurse (LN) I stated residents call lights should always be within a resident's reach. She stated it was every staff member's duty to ensure call lights were within reach.On 03/04/26 at 08:04 AM, Administrative Nurse D stated residents should always have their call light where they can reach it. She stated the facility does on the spot training and in services on where to place a residents call light.The facility's Call Light System policy, revised 04/19 documented the community would have a call button or pull cord located next to each bed and in each resident's bathroom.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. The facility had a census of 51 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to keep Resident (R) 58s protected health information (PHI) private on a medication cart that sat against the wall in A hall.Findings included: - On 03/03/26 at 08:29 AM, an observation revealed a medication cart parked against the wall in the A hall with a laptop computer sitting on the top. Certified Medication Aide (CMA) R walked away from the medication cart and into a resident's room. CMA R left the computer screen unlocked and opened and R58's PHI was on the screen, visible to all who passed by the medication cart. The information visualized included R58's medications, date of birth , allergy information, and code status. On 03/03/26 at 08:37 AM, CMA R stated she had stepped away from the cart to help a resident. She stated the policy was to ensure the CMA locked the medication cart and pushed the hide button. On 03/04/26 at 08:17 AM, Licensed Nurse (LN) I stated medication carts should be locked and the screen on the laptop should be closed, or staff could push the hide button, if the laptop was out of the staff's visual.On 03/04/26 at 08:04 AM, Administrative Nurse D stated the policy was to lock the medication cart. She stated nursing staff have the option to close the laptop or push the hide the screen button. She stated staff have been in-serviced on how the medication cart and laptop should be left, when the laptop or cart was not in their line of sight. The facility's Confidentiality policy, revised on 02/25 documented confidentially must be maintained in all areas of health information, whether oral, written, or electronic. Personnel must keep residents' information confidential except as permitted for continuity of care. Although information sharing was necessary in the healthcare environment confidentiality was breached when the information can be intercepted by unauthorized persons and connected to a specific individual.

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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** The facility reported a census of 51 residents; the sample included 14 residents, with 9 residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide follow-up fall assessments for Resident (R) 4 and failed to assess for R7's ability to safely use an electric recliner until after a fall occurred.Findings included:- R7's Electronic Medical Record (EMR) recorded diagnoses of, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), restless leg syndrome (RLS - neurological disorder causing painful urge to move the legs, accompanied by creeping, crawling, or tingling,) and peripheral neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet. R7's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. R7 required staff supervision with bed mobility and transfers. The Cognitive Loss Care Area Assessment (CAA), dated 04/21/25, recorded R7 had cognitive impairment. The Fall CAA, dated 04/21/25, did not trigger. The Activities of Daily Living (ADL) Care Plan, dated 04/21/25, directed staff to provide R7 set up to supervision assistance with most ADLs, nursing was to monitor declines, and provide therapy if needed. The ADL CAA documented R7 had impaired mobility and a self-care deficit due to impaired vision, impaired hearing, morbid obesity, and pain. The Fall Care Plan, dated 04/22/25, documented the resident was at risk for falls due to impaired vision, impaired hearing, right and left foot drop, and neuropathy. The care plan documented staff would have the resident's call light within reach and encourage the resident to use it for assistance as needed. The care plan documented the staff would ensure the resident wore appropriate footwear when ambulating or mobilizing in the wheelchair. The care plan documented staff would monitor the residents for declines The Fall Risk Assessment, dated 10/07/25 and 12/05/25, documented a score of 13.0, indicating R7 was at risk for falls. The electronic Health records lacked an assessment for the use of a lift chair for R7. The Nurse's Note, dated 12/05/25 at 01:25 AM, recorded the resident had a fall from her lift recliner when she raised the recliner to a high position and slid forward out of the recliner. Staff heard the resident yelling and upon entrance to R7's room, noted she was sitting on the floor on her bottom, with her legs stretched out in front of her. R7's recliner was noted to be all the way up. R7 verbalized she attempted to get out of her recliner and raised it too far, causing her to slide out of the chair and onto the floor. An assessment was completed and revealed R7 sustained a skin tear to her left upper hand measuring 1.4 centimeters (cm) by 1.0 cm. No other injuries were noted. Staff assisted R7 from the floor and returned her to the recliner with three staff assistance and the total body mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 12/05/25 at 07:21 AM, instructed staff to cleanse the resident's skin tear to the back of R7's hand with skin cleanser, apply an antibiotic ointment, then cover with a dressing one time a day for three days and discontinue when healed. The Nurse's Note, dated 12/05/25 at 12:01 PM, documented R7's daughter agreed to disable the lift/recliner's automated functions and stated she would come to the facility and visit with the resident to lessen R7's anxiety with the change. On 03/02/26 at 11:30 AM, observation revealed R7 seated in her recliner and dressed in street clothes. The resident sat half off of the chair and scooted to the end of the recliner, yelling it was hot in her room and told staff to open her window. On 03/04/26 at 09:30 AAM, Administrative Nurse D verified the resident had a fall out of her electric recliner chair in December 2025. Administrative Nurse D verified the resident had impaired cognition and stated R7's family brought the electric lift recliner to her in October 2025, and the facility failed to complete an electric lift chair assessment at that time. Administrative Nurse D verified a lift chair assessment should have been completed when the chair arrived, yearly, and with a change of condition. The facility's Falls policy, dated 11/01/24, documented resident would be identified for risk of falls and interventions implemented to reduce risk. A Fall Risk Evaluation Tool would be completed for a resident on admission, quarterly and when there is a significant change of condition, and as applicable after a fall and if the resident was a high-risk status, that would be documented on the Comprehensive Plan of Care. - R40's Electronic Medical Records (EMR) documented diagnoses that included repeated falls, right arm fracture, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), difficulty walking, and muscle weakness. R40's 07/03/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented R40 had a fall with a major injury. R40's Falls Care Area Assessment documented R40 was at risk for falls related to a history of falls, including a fall with a fracture, incontinence, impaired vision, impaired mobility, and medication use. R40's Care Plan documented R6 was at risk for falls; revised on 07/03/25, and documented R40 has been instructed to use her call light for assistance and directed staff to reinstruct as needed. R40's Incident Note dated 07/01/25 at 03:05 documented R40 laid on her right side with her right arm pinned underneath her on the floor in her room with blood droplets on the carpet. R40's right wrist was swollen. R40 had a skin issue on the right upper eye and the right side of her forehead. R40 was bleeding near her eye and swelling to the right upper eye and forehead. The provider was notified, and R40 was sent to the emergency room. The Neurological Checks for fall on 07/01/2025 at 07:20 AM have the initial check with vital signs from 03:15 PM. The second 15-minute check has vital signs from 03:18 PM. The third and fourth 15-minute checks, the two 30-minute checks and the first 60-minute checks were not completed because R40 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in the hospital. The second 60-minute check documented was completed on 07/01/25 at 10:00 AM, but the vital signs were from 03:29 PM. The third 60-minute check documented was completed at 07/01/25 at 12:14 PM, but the vital signs were documented at 03:32 PM. The fourth 60-minute check lacked a time it was completed, but the vital signs were time-stamped 06/29/25 at 07:00 AM, prior to the fall. The first shift check lacked a time it was completed, but the vital signs were time-stamped 06/29/25 at 07:00 AM, prior to the fall, and no assessment was completed. The fourth shift check lacked a time it was completed, but the vital signs were time-stamped 06/29/25 at 07:00 AM, prior to the fall, and no assessment was completed. The seventh shift check lacked a time it was completed, but the vital signs were time-stamped 06/29/25 at 07:00 AM, prior to the fall, and no assessment was completed. On 03/03/26 at 07:45 AM, R40 was independent in her room and walked into the bathroom. On 03/03/26 at 7:51 AM, R40 independently walked with her walker to the dining area, R40 parked her walker next to the wall and got into her chair without assistance. On 03/04/26 at 8:44 AM, Certified Nurse Aide (CNA) P stated when a resident fell, the nurses assessed the resident and documented vital signs for several days after. On 03/04/26 at 9:00 AM, Certified Nurse Aide (CNA) H stated the nurse completed a head-to-toe assessment when a resident fell. The nurse checked vital signs and started neurological assessments, notified the doctor and family. The nurse on duty opened the neurological assessment that they used to document the follow up neuros. The nurse completed the Post Fall Assessment and started the risk management. The nurse always started neurological checks if the fall was not witnessed or if the resident hit their head. On 03/04/26 at 12:03 PM, Administrative Nurse D stated when a resident fell the nurse was to assess the resident for injury which included vital signs and a neurological assessment. They assist the resident up or call emergency medical assistance. Start the neurological assessments unless you can prove they did not hit their head. Complete the other assessments. The facility's policy Neurological Assessment dated` 02/03/25 documented the neurological screening is conducted by a licensed nurse on residents who sustain a head injury. The neurologic screening in the EMR is completed every 15 minutes for an hour, them ever 30 minutes for an hour, then every hour for four hours, then every four hours for 16 hours, then every shift for three days.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility identified a census of 51 residents. The sample included 14 residents, including five residents reviewed for unnecessary medications. Based on record review, interview and observation, the consulting pharmacy failed to identify blood sugars out of range for Resident (R) 3.Findings included:- R3's Electronic Medical Records (EMR) documented diagnoses, which included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R3's 05/06/2025 admission Minimum Data Set (MDS) documented R3 had a Brief Interview for Mental Status (BIMS) of 13, indicating intact cognition. The MDS noted R3 had a diagnosis of diabetes and received an insulin injection every day in the look back period of seven days. The Nutrition Care Area Assessment (CAA) documented R3 was at risk for impaired nutrition related to a stroke, morbid obesity, and diabetes. R3's Care Plan dated 05/06/25 documented that R3 takes insulin and oral diabetes medications and directed staff to monitor and document side effects and effectiveness. Intervention on 08/03/25 directed the staff to check her fasting blood sugar as ordered and to notify the provider of readings less than 60 milligrams per deciliter (mg/dl) or greater than 350 mg/dl. R3's Physician Orders in the EMR documented an order for blood glucose monitoring two times a day. Call the doctor if the blood glucose level is less than 60 mg/dl or over 350 mg/dl; dated 07/29/25. Review of R3's blood glucose record under the Weights and Vitals tab for July 2025 through February 2026 found the following:07/07/25 a blood glucose level of 376 mg/dl07/08/25 a blood glucose level of 377 mg/dl07/09/25 a blood glucose level of 393 mg/dl07/11/25 a blood glucose level of 409 mg/dl07/12/25 a blood glucose level of 363 mg/dl07/13/25 a blood glucose level of 362 mg/dl07/14/25 a blood glucose level of 423 mg/dl07/15/25 a blood glucose level of 382 mg/dl07/18/25 a blood glucose level of 382 mg/dl07/19/25 a blood glucose level of 418 mg/dl07/21/25 a blood glucose level of 406 mg/dl07/22/25 a blood glucose level of 365 mg/dl07/23/25 a blood glucose level of 418 mg/dl08/01/25 a blood glucose level of 411 mg/dl08/13/25 a blood glucose level of 366 mg/dl08/27/25 a blood glucose level of 596 mg/dl09/01/25 a blood glucose level of 357 mg/dl09/05/25 a blood glucose level of 372 mg/dl09/09/25 a blood glucose level of 442 mg/dl09/10/25 a blood glucose level of 369 mg/dl09/17/25 a blood glucose level of 442 mg/dl09/29/25 a blood glucose level of 455 mg/dl10/03/25 a blood glucose level of 386 mg/dl11/03/25 a blood glucose level of 391 mg/dl11/11/25 a blood glucose level of 357 mg/dl11/24/25 a blood glucose level of 363 mg/dl12/31/25 a blood glucose level of 397 mg/dl01/10/26 a blood glucose level of 352 mg/dl01/12/26 a blood glucose level of 351 mg/dl01/27/26 a blood glucose level of 369 mg/dl02/04/26 a blood glucose level of 421 mg/dl02/14/26 a blood glucose level of 359 mg/dl02/20/26 a blood glucose level of 358 mg/dl02/22/26 a blood glucose level of 353 mg/dl02/24/26 a blood glucose level of 355 mg/dl R3's Progress Notes in the EMR lacked notification to the provider for blood glucose over 350 mg/dl for the above dates. Review of the Drug Regimen Review (DRR) from August 2025 to February 2026 showed no documentation that the blood sugars were identified by the pharmacist as being out of range. On 03/02/26 8:19 AM, R3 laid in bed with her over bed table close to the side of the bed. R3 stated she preferred to stay in bed and staff bring her breakfast to her. On 03/04/26 at 12:03 PM, Administrative Nurse D stated she expected the pharmacist to know when a medication was out of the parameter and to notify the facility. The facility's Drug Regimen Review dated 08/2024 documented the pharmacist will complete a drug regimen review monthly and when needed, and identify medication without proper monitoring.

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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. The facility identified a census of 51 residents. The sample included 14 residents, including five residents reviewed for unnecessary medications. Based on record review, interview and observation, the facility failed to follow orders for notification of the provider for blood sugars out of range for Resident (R) 3.Findings included:- R3's Electronic Medical Records (EMR), documented diagnoses which included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R3's 05/06/2025 admission Minimum Data Set (MDS) documented R3 had a Brief Interview for Mental Status (BIMS) of 13, indicating intact cognition. The MDS noted R3 had a diagnosis of diabetes and received an insulin injection every day in the look back period of seven days. The Nutrition Care Area Assessment (CAA) documented R3 was at risk for impaired nutrition related to a stroke, morbid obesity and diabetes.R3's Care Plan dated 05/06/25 documented that R3 takes insulin and oral diabetes medications and directed staff to monitor and document side effects and effectiveness. Intervention on 08/03/25 directed the staff to check her fasting blood sugar as ordered and to notify the provider of readings less than 60 milligrams per deciliter (mg/dl) or greater than 350 mg/dl.R3's Physician Orders in the EMR documented an order for blood glucose monitoring two times a day. Call the doctor if the blood glucose level is less than 60 mg/dl or over 350 mg/dl; dated 07/29/25.Review of R3's blood glucose record under the Weights and Vitals tab for July 2025 through February 2026 found the following:07/07/25 a blood glucose level of 376 mg/dl07/08/25 a blood glucose level of 377 mg/dl07/09/25 a blood glucose level of 393 mg/dl07/11/25 a blood glucose level of 409 mg/dl07/12/25 a blood glucose level of 363 mg/dl07/13/25 a blood glucose level of 362 mg/dl07/14/25 a blood glucose level of 423 mg/dl07/15/25 a blood glucose level of 382 mg/dl07/18/25 a blood glucose level of 382 mg/dl07/19/25 a blood glucose level of 418 mg/dl07/21/25 a blood glucose level of 406 mg/dl07/22/25 a blood glucose level of 365 mg/dl07/23/25 a blood glucose level of 418 mg/dl08/01/25 a blood glucose level of 411 mg/dl08/13/25 a blood glucose level of 366 mg/dl08/27/25 a blood glucose level of 596 mg/dl09/01/25 a blood glucose level of 357 mg/dl09/05/25 a blood glucose level of 372 mg/dl09/09/25 a blood glucose level of 442 mg/dl09/10/25 a blood glucose level of 369 mg/dl09/17/25 a blood glucose level of 442 mg/dl09/29/25 a blood glucose level of 455 mg/dl10/03/25 a blood glucose level of 386 mg/dl11/03/25 a blood glucose level of 391 mg/dl11/11/25 a blood glucose level of 357 mg/dl11/24/25 a blood glucose level of 363 mg/dl12/31/25 a blood glucose level of 397 mg/dl01/10/26 a blood glucose level of 352 mg/dl01/12/26 a blood glucose level of 351 mg/dl01/27/26 a blood glucose level of 369 mg/dl02/04/26 a blood glucose level of 421 mg/dl02/14/26 a blood glucose level of 359 mg/dl02/20/26 a blood glucose level of 358 mg/dl02/22/26 a blood glucose level of 353 mg/dl02/24/26 a blood glucose level of 355 mg/dl R3's Progress Notes in the EMR lacked notification to the provider for blood glucose over 350 mg/dl for the above dates. On 03/02/26 8:19 AM, R3 laid in bed with her over bed table close to the side of the bed. R3 stated she preferred to stay in bed and staff bring her breakfast to her. On 03/04/26 at 12:01 PM, Certified Medication Aide (CMA) R stated that the CMAs do the Accu-check (blood glucose monitoring test) and stated there are no parameters of when to notify the nurse or doctor. CMA R stated she notified the nurse if the blood sugar was under 100 mg/dl or over 185 mg/dl. On 03/04/26 at 12:03 PM, Administrative Nurse D stated nursing staff should notify the physician if the resident was symptomatic. Administrative Nurse D said staff usually faxed the doctor if the blood sugar was over /dl if the resident is not symptomatic. The nurse should document if she faxed or called and what the physician's response was. The facility's Notification Parameters- Primary Care Provider (PCP) dated 02/03/25 documented notification of the PCP in a timely, efficient, and effective manner can be accomplished when a system is consistently followed by licensed (continued on next page)

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	175304	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing staff. Licensed nursing staff have the responsibility of contacting a PCP anytime a resident has developed a clinical problem requiring PCP intervention.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 51 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 8 remained free of significant medication errors when staff failed to administer his potassium (a medication for hypokalemia (low level blood potassium in the blood) ordered by physicians.Findings included:- R8's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of fluid overload, hypokalemia (low potassium), hypertension (elevated blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), unsteadiness on feet, muscle weakness, and repeated falls.The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R8 received a diuretic (a medication to promote the formation and excretion of urine).R8's Dehydration/Fluid Maintenance Care Area Assessment (CAA) dated 01/22/26 documented a risk for dehydration related to the use of diuretics, impaired mobility, a wound, dementia, and constipation.R8's Care Plan documented the following:01/28/26-R8 was at risk for adverse reactions related to polypharmacy, and the use of Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). R8 would be free from adverse drug reactions through the review date.R8's EMR under the Discontinued Orders tab revealed the following physician order:Potassium oral tablet, give 40 milliequivalent (mEq) by mouth three times a day related to hypokalemia until 02/17/26Review of the R8's Medication Administration Record (MAR) for February 2026 documented on 02/13/26: Pending confirmation, potassium oral tablet give 40 mEq by mouth three times a day related to hypokalemia until 02/17/2026. Start Date 02/14/2026 08:00 AM -Discontinue Date 02/20/2026.R8's clinical record lacked evidence that the potassium dose was administered or rescheduled and lacked evidence the physician was notified that the medication was not administered as ordered on starting 02/14/2026.On 02/13/26 at 05:00 PM, a Health Status Note documented the nurse received an order form Nurse Practitioner. The note stated new order for R8 whose potassium level was low; take Potassium 40 mEq three times a day for three days then recheck A Comprehensive Metabolic Panel (CMP) (a routine blood test) and magnesium level on Tuesday, 02/17/26.On 02/18/26, a Fax Form Non-Immediate Communication was faxed to the physician documented facility had received a verbal or [NAME] on 02/13/26 for Potassium 40 mEq three times a day for three days related to low potassium levels. This medication was missed and R8 did not receive the prescribed dose. Potassium level was rechecked on 02/17/26 with result of 3.8. The physician's response was, no need for potassium at this time.On 02/20/26 at 07:08 AM under Heath Status Note documented received response from physician concerning the following clarification requests: R8 does not require strict intake and output monitoring. Exchange Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) with a 16French (type of foley) today and every 30 days. Potassium rechecked on 02/17/26 with a result of 3.8, no need for potassium.On 03/04/26 at 08:04 AM, Administrative Nurse D stated the potassium for R8 was missed. She stated the nurse on duty had not worked for several years. Administrative Nurse D stated the nurse on duty put the order in Pending, and the order never went on the MAR. She stated the second check for each order was the medical records nurse, since the order was stuck in Pending the second check was unable to catch the error. Administrative Nurse D stated as soon as the error was caught, a note was faxed to the physician.The facility's Medication Error policy, revised 02/25, documented the community would ensure that residents are free of any significant medication errors. Medication errors would be immediately reported to the physician and director of nursing or designee. Medication errors would be documented on care Incident Tracking Report. Notify resident's (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party. If medication errors originated at the pharmacy, the pharmacy would be notified immediately. Medication errors would be tracked for quality insurance purposes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 51 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to ensure staff labeled Resident (R)11's insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened. Findings included:- On 03/02/26 at 07:15 AM, observation of the Medication cart located in the nurse's room revealed R11's Lantus (long-acting insulin) flex pen was not labeled with an opened date or an expiration date. R11's second Lantus insulin flex pen had an illegible date written on the pen as it had smeared and was not legible. On 03/02/26 at 07:20 AM, License Nurse G verified the nurses should label and date the insulin flex pens with the date opened. On 03/04/26 at 10:20 AM, Administrative Nurse D verified the nurse should label and date the insulin flex pens with the date opened. Medlineplus.gov directs open, unrefrigerated insulin pen can be used within 28 days; after that time, they must be discarded. The facility's Medication Storage policy, dated 02/03/25, documented medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. Medications are accessible only to licensed nurses, pharmacy personnel, or staff members lawfully authorized to administer medications. Medications are labeled for individual residents and stored separately from floor stock medications when not in the medication cart.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 51 residents. The sample included 14 residents with one reviewed for dental care. Based on observation, record review, and interview, the facility failed to provide timely dental care for one sampled resident, Resident (R) 6.Findings included:- R6's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R6 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The assessment revealed R6 required staff assistance for personal hygiene, oral hygiene, toilet hygiene and had no oral or dental issues.The Care Area Assessment (CAA), dated 04/28/25, for activities of daily living (ADLs) failed to identify or document any sign/symptoms of dental problems or pain due to the broken, decayed, and missing teeth.The Activities of Daily Living (ADL) Care Plan, dated 01/12/26, recorded R6 required limited to extensive staff ADLs such as grooming, dressing, toileting and dressing. The Care Plan documented R6 had his own teeth, and they were in poor condition, carries and missing teeth and he required set up to partial assistance with oral cares. The care plan documented dental appointments would be set up as scheduled, needed and requested. The Interdisciplinary Notes dated 07/07/25, documented R6 had a dental appointment with Health Department -Dental due to a lost tooth and mouth pain. The notes documented R6 saw a dentist and the dentist documented he had extensive gross caries. The dentist recommended that staff brush R6's teeth and the patient would return to have fillings and extractions completed. However, the note documented the extractions would have to be performed by an oral surgeon not at the dentist's office. The 03/03/26 at 11:10 Interdisciplinary Notes, documented the resident was seen at the facility by a dental hygienist for a routine periodontal maintenance exam, and she documented R6 had pain in his upper left mouth and to the root tip area. The notes documented in the visual exam revealed moderate inflammation in the area and R6 would need further evaluation with the dentist. On 03/02/26 at 10:30 AM, R6 stated he had broken missing teeth, and had pain located in his right upper jaw area. R6 stated he had difficulty eating due to the tooth pain. Observation of R6's mouth revealed he had missing, decayed teeth and some broken off. On 03/04/26 at 09:30 AM, Administrative Nurse D verified the resident had broken, decaying teeth and had a dental appointment on 07/07/25 and verified the dentist's notes recommended filling and extractions. Upon review, Administrative Nurse D could not find any written documentation if a follow-up appointment was made after the 07/07/25 appointment and if it not the reason and follow treatment appointment was not made. Administrative Nurse verified there was no documentation in R6's medical records. Administrative Nurse D verified if R6 would have pain he should be evaluated by a dentist for recommendations and verified the residents should not have dental pain and not get treated for the pain. The facility's Dental Service policy, dated 02/03/25, documented residents are assessed for oral/dental needs initially, periodically and reviewed annually. The residents are referred to a dentist requested from the primary care physician for any identified or verbalized oral complaint/issue. Staff assist the residents to make an appointment and arrange transportation to and from the dentist's office. The policy documented for emergencies or oral discomfort, staff would obtain an order from the primary care physician and arrange for dental appointment within three days. The policy documented if the resident or responsible party refuses dental treatment, the nurse's notes it in the medical record and documents education as to risks to health status if no dental services are provided. The policy documented staff would record in the medical record interventions used to facilitate residents' ability to eat and drink while awaiting dental services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 51 residents with one kitchen. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and preparation to prevent the spread of food borne illness to the residents of the facility. This placed the residents at risk for food-borne illness.Findings included:- Initial tour of the kitchen on 03/02/2026 at 07:29 AM with Dietary Manager BB, revealed the following areas of concern:An uncovered plastic tub containing metal spoons sitting on counter in dining area at entrance to kitchen.Five blocks of butter in a metal container uncovered on the counter.The refrigerator contained bowls of spaghetti, milk, cottage cheese, and yogurt on a tray covered with plastic wrap r with no open or use by date.The freezer contained 5 cups of pudding and a piece of pie, two packages of shredded cheese, 2 sheet pans of Jello and 7 sausage links that were not labeled and dated.The spice rack on the wall behind the stove had an open package of brown sugar that did not have an opened-on date. A container labeled turmeric with a use by date of 9/15/24 and a sticker on the container with an open date of 11/6/23 and a use by date of 11/5/24, a container labeled as crushed red pepper flakes, with a use by 3/21/25, a container of curry powder with an attached label showing opened on 11/6/23 and use by 11/5/24.A table in the kitchen against a wall had six stacks of plates that were not inverted.A container on a counter with numerous cake decorating gels. One decorating gel was dated opened on 5/1/25 by 11/6/25, and a container of colored sugar with an opened date of 11/22/24 and a use by date of 5/21/25.Observation on 03/02/2026 during kitchen tour, dietary staff FF, was not wearing a hair net underneath the ball cap they had on.Observation on 03/03/26 at 11:00 AM, during the pureed preparation, Dietary Staff FF did not change gloves or perform hand hygiene between tasks or when gloved hands were exposed to a new location or an unclean environment.Observation on 03/03/26 at 12:40 PM, Dietary Staff FF placed a cloth over the cap on the blender container during the blending cycle, (the cap had a large opening that a utensil for stirring could be placed through), the cloth was placed on counter in between blends, there were several clean & dirty cooking utensils and food debris on the counter's surface. Staff FF then placed the same cloth back on the blender cap for each blender cycle of each food item for the entire pureed meal preparation. Observation on 03/03/26, Staff FF did not properly sanitize the thermometer being used to obtain temperatures on the pureed food. Staff FF used a paper towel to wipe off the thermometer while obtaining temperatures on 3 different pureed food items.Observation 03/03/26 at 12:42 PM, Dietary Staff EE carried a plate of food from the kitchen to a resident in the dining room. Dietary Staff EE placed thumbs on the easting surface of the plate.On 03/04/2026 11:34 AM, Dietary Staff BB reported that all staff should perform hand washing at kitchen entry, kitchen re-entry and between tasks performed in the kitchen. Hand washing should also be performed in between gloving or when handling ready-to-eat foods. Changing gloves and hand hygiene should be done after every task; Any prepped or stored food should be covered & labeled with an opened on & use by date; All spices on the rack for use in the kitchen should be labeled and the expired spices should be thrown out. Hair net or a facial cover should always be worn when in the kitchen or anytime staff are around food. Counters, utensils, thermometers, towels and cooking vessels should be cleaned, sanitized and replaced with new if in contact with an unclean surface or item.On 03/04/2026 11:56 AM, Administrative Staff A reported that every time kitchen staff make a new order, any task or change gloves they should wash their hands or use hand sanitizer. All staff should wear a hairnet when they are in the kitchen or serving food. Staff should not put their thumbs or any part of their hand on the rim of the plate when carrying it to serve the residents. All food items should be labeled with a use by and the date it was wrapped. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All dedicated utensils/Clean utensils, cooking or food prep vessels and counters, if compromised, should be replaced new one or the compromised item should be washed and sanitized before use again. Any thermometer used should be sanitized between uses. The facility Policy 5.01 HACCP Food Handling Principles dated 02/2026, documented that utensils, equipment, and surfaces are clean and sanitized prior to, and between uses. Employees are trained in safe food service techniques and personal hygiene annually, or more often as needed. All products are labeled and dated with the receiving date. Once opened, products are covered to prevent contamination and dated with an open date.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 51 residents. The sample included 14 residents with five reviewed for immunization status. Based on record reviews and interviews, the facility failed to offer and administer or obtain an informed declination for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial pneumonia infections) vaccination for Resident (R)3Findings included:- Review of R3's clinical record revealed the PCV13 was administered on 10/30/15, and the PSV23 was administered on 11/12/04. R3's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or a physician documented contraindication.On 03/04/26 at 08:04 AM, Administrative Nurse D stated the nurse who admitted the resident was responsible for ensuring the resident or family signed a consent or declination for immunizations. Administrative Nurse D stated the signed consent or declination form was uploaded in the resident's chart and Administrative Nurse D was notified if the resident was to receive any immunizations. Administrative Nurse D stated she was unable to find the consent or declination for R3 as the room the forms had been stored in had flooded. She stated R3 had signed the consent on 03/03/26 and the immunization was administered.The facility's Immunizations-Pneumococcal policy, revised 04/14/25, documented residents were provided the opportunity and encouraged to receive the Pneumococcal vaccines. At the time of admission, the nurse would determine the residents' vaccination history by resident information, the family or primary care provider and document on the immunization record.