STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175315	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pratt Health and Rehab	1221 Larimer Street Pratt, KS 67124

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	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 38 residents. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions for Resident (R) 8, who had dressing changes to a pressure ulcer daily. The facility also failed to implement a complete water management program for Legionella disease (Legionella is a bacterium spread through mist, such as air-conditioning units in large buildings. Adults over the age of 50 and people with weak immune systems, or chronic lung diseases). Findings included:-R8's Electronic Medical Record (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, cardiac murmur (abnormal sound), and hypertension (elevated blood pressure). R8's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R8 had severe cognitive impairment. The MDS further documented that R8 had an unhealed Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) not present on admission. R8's Care Plan, dated 02/07/26, documented R8 had a pressure ulcer to the coccyx (area at the base of the spine) and directed staff to provide wound care daily. The plan further directed staff to monitor nutritional status, reminding and assisting R8 to turn/reposition at least every two hours and more often if needed, assess/record/ monitor wound healing on a weekly basis, and require the use of a therapeutic mattress. The Wound Care Consultant Progress Note dated 01/07/26, documented that R8 had developed a Stage 3 midline coccyx pressure ulcer. The wound had slough (dead tissue, usually cream or yellow in color) and was debrided (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue). The consultant ordered hydrogel (a water-based gel that donates moisture and aids autolytic debridement) and foam dressing treatment. The ulcer measured 2.5 centimeters (cm) in length and 0.7 cm in width. On 03/16/26 at 02:26 PM, R8 lay on a low air mattress, with the bed in a low position towards the floor. Licensed Nurse (LN) H assisted R8 to roll in bed to her side. LN H donned gloves but did not don a gown and provided wound care. On 03/17/26 at 11:57 AM, Administrative Nurse D reported that EBP utilization of gloves and gowns should be implemented for open wound treatment. On 03/17/26 at 09:25 AM, Maintenance Staff U verified there was no mapping of the facility water flow system, including entering, flow direction, areas of potential water collection, and the hot water system of the facility. Maintenance Staff U reported water samples were tested from the kitchen, and from each wing, though unspecific locations within the facility were sent for detection of Legionella. The report dated 02/26/26 documented that the water samples did not detect Legionella. The facility's Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) policy, dated 04/2025, documented definition of EBP expands the use of Personal Protective Equipment (PPE) and refers to the use of a gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	colonization with MDROs. The use of a gown and gloves for high-contact resident care activities is indicated. The facility's Water Management, Legionella Testing policy, dated 04, 2025, documented that the facility handles and maintains its water supply in accordance with recommendations of the Centers for Disease Control and Prevention (CDC), the Healthcare Infection Control Practices Advisory (HICPAC) Committee, and the Food and Drug Administration (FDA). The community will demonstrate its measures to minimize its risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility had a census of 38 residents. The sample included 12 residents, with three reviewed for Medicare Liability Notices. Based on record review and interview, the facility failed to provide Resident (R) 8, R10, and R17, or their representative, a Notice of Medicare Non-coverage (NOMNC) when skilled services ended.Findings included:-A review of R8's Electronic Medical Record (EMR) documented that her Medicare Part A episode began on 10/23/25 and ended on 01/09/26. Review of R8's clinical record and facility-provided information lacked evidence that R8 was issued a SNF NOMNC as required. A review of R10's EMR documented that his Medicare Part A episode began on 06/27/25 and ended on 08/21/25. Review of R10's clinical record and facility-provided information that lacked evidence of R10 was issued a SNF NOMNC as required. A review of R17's EMR documented that his Medicare Part A episode began on 05/03/25 and ended on 07/22/25. Review of R17's clinical record and facility-provided information that lacked evidence of R17 was issued a SNF NOMNC as required. On 03/16/26 at 02:28 PM, Administrative Nurse D provided the requested Skilled Nursing Facility Advanced Beneficiary Notice (ABN) for R8, R10, and R17, but lacked NOMNC notices. Administrative Nurse D verified that the residents or their representatives had not received a NOMNC notice due to personnel changes in the department that handled the notices. The facility's Beneficiary Notices policy, dated 07/2025, documented that a Medicare beneficiary has the right to have Medicare make the decision to determine if skilled services will not be covered by Medicare. Two processes are available: the expedited appeals process and the standard appeals process. The standard appeals process serves a similar function to services continuing without interruption. The standard appeals process serves a similar function of enabling a beneficiary to seek Medicare payment for a Skilled Nursing Facility (SNF) stay, but it is also necessary to inform the beneficiary of possible non-coverage and, if Medicare agrees that the coverage is not appropriate, to shift the costs of care from the SNF to the beneficiary. A notice of NOMNC is prepared and given at least three days before the end of the Medicare Part A stay or when all Part B therapies are ending. Forms should be maintained in a binder with Social Services. A copy can be maintained in the Business Office as well.

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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 identified a census of 38 residents. The sample included 12 residents, with two residents reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 29 and R40 and their representative were provided with a written notification of transfer, that included a statement of the right to appeal and the state ombudsman information, upon their transfer to the hospital as soon as practicable. The facility failed to ensure R40 had a discharge summary and recapitulation of stay completed upon her discharge from the facility. Findings included:1. R29's Electronic Medical Record (EMR) recorded a Discharge Minimum Data Set (MDS) dated [DATE], which documented an unplanned discharge to an acute hospital with a return anticipated.R29's Entry MDS dated 07/18/25 documented a re-entry to the facility from an acute hospital.R29's Notice of Transfer form, dated 07/10/25, documented that the form was provided to the resident's representative. The Notice of Transfer form lacked information containing a statement of the resident's appeal rights, including the name, address, and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman.R29's EMR recorded a Discharge MDS dated 11/18/25, which documented an unplanned discharge to an acute hospital with a return anticipated.R29's EMR lacked evidence of written notification of transfer. Upon request, the facility was unable to provide evidence of notification to the state ombudsman of R29's transfer to the hospital on [DATE] and 11/18/25.2.R40's EMR recorded a Discharge MDS dated 02/11/26, which documented an unplanned discharge to an acute hospital with a return anticipated.R40's Notice of Transfer form dated 02/11/26 was provided to the residents' representative. The Notice of Transfer form lacked information containing a statement of the resident's appeal rights, including the name, address, and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman.R40's Social Services Note dated 02/25/26 at 05:52 PM, documented that R40's guardian and five other people came to the facility and removed R40's personal belongings. The guardian decided to move the resident to another community. The guardian signed the inventory sheet and would return tomorrow to pick up R40's remaining items.R40's EMR lacked proof that a Discharge Summary and recapitulation of stay were completed by the facility that contained all required information upon her discharge on [DATE]. On 03/15/26 at 02:31 PM, Social Services X stated the ombudsman was not notified at the time of transfer and subsequent admission to the hospital. Social Services X said the facility notified the Ombudsmen at the end of the month if a resident's bed hold was released. Social Services X said that the facility completed a notice of transfer, and if the family came into the facility, staff gave a written copy. Social Services X said for the most recent transfers, staff sent electronic notices to the representative and said the facility would be updating the Notice of Transfer form with the required information. She stated a discharge summary was completed upon R40's discharge, but a full discharge summary did not include all the complete information needed or the recapitulation of the stay. The facility's Transfer and/or Discharge, Including Against Medical Advice (AMA), Discharge Notification policy dated October 2025, documented: the resident, and/or representative will be provided with the following information within the notice, in writing and language and manner they understand, prior to transfer: the reason for the transfer or discharge, and the reasons for the move in writing and in a language and manner they understand; the effective date of the transfer or discharge; the specific location (such as the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged ; a (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement of the resident's appeal rights, including the name, address (mailing and email) and telephone number of the entity which receives such requests; and information on how to obtain the appeal form and assistance in completing the form and submitting the appeal hearing request. The name, address, (mailing and email) and telephone number of the state long-term care ombudsman; The name, address, mailing and email address, and telephone number of each individual or agency responsible for the protection and advocacy of mentally ill or developmental disabled individuals (as applies); and the name, address, mailing and email address and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. The above transfer or discharge information will be documented in the resident's chart. Send a copy of the notice to the State Long Term Care Ombudsman and note it in the record. The facility's Discharge Summary and Plan policy dated April 2025 documented that the discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The recapitulation will include, but not be limited to, diagnoses; course of illness, treatment or therapy; pertinent lab, radiology, and consultation results; reconciliation of all pre-discharge medications with the resident's post-discharge medications, for prescribed and over-the-counter. A final summary paragraph that may be released to any provider with the consent of the resident or representative.