STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 34, with 14 residents in the sample, and one resident reviewed for substance use disorder. Based on observation, interview, and record review the facility failed to prevent, identify, and intervene in Resident (R) 11's substance use disorder, which placed residents in immediate danger of serious harm or death. R11' Electronic Health Record revealed a history of substance use disorder, charting to indicate signs and symptoms of active substance use, and two instances of the resident having drug paraphernalia in his room. On [DATE] at 02:14 PM facility staff saw a green tackle box and a red basket on the floor in R11's room which contained pill bottles, lighters, books, and other items scattered next to it. The red basket had a torch, four pill bottles, a red lighter, a large knife, and a black pouch containing a drug pipe. On [DATE] at 09:30 PM staff were asked to check on R11 due to suspicion of drug use, and upon a search they found a crack pipe with methamphetamine still in the bowl and a lighter in a glasses case. The resident had pinpoint eyes, a severely red face, and appeared intoxicated. The resident refused transport to the hospital and law enforcement declined to transport the resident out of the facility due to his medical conditions. The facility failed to implement any monitoring of the resident for continued substance use, withdrawal, and or other self-harm actions. The facility staff failed ensure the safety of all resident's in the facility when they removed the crack pipe from the resident's room with the methamphetamine still in the bowl of the pipe spilled it over the top of the medication cart, which housed other resident medications and potentially exposed any residents in the vicinity (including those with known SUD) to the toxic substance. Staff utilized gloves and cleaned the cart. The Administrator and/or Regional Nurse were notified of the incidents on [DATE] and [DATE] but failed to act on the incidents. By allowing the resident to smoke methamphetamine inside the building while in possession of a knife, torch, lighter and non-prescribed pills the facility created multiple high-risk conditions including fire and explosion risk, physical injury risk, drug exposure and overdose risk, impaired judgement and unpredictable behaviors as well as delayed emergency response by facility staff. The combination of illegal substance use, possible weapons, and ignition sources inside the facility along with lacking supervision and care planning put all resident's health and safety in Immediate Jeopardy. The facility further failed to determine a root cause analysis and implement fall precaution interventions after falls for R32 and failed to use a gait belt during transfers for R16.The facility Administrator was notified of the Immediate Jeopardy (IJ) on [DATE] at 1:18 PM and remain ongoing.Findings included:- Review of R11's Electronic Health Record (EHR) revealed the following diagnoses: alcoholic liver disease, psychoactive substance abuse (in remission), and other stimulant abuse (uncomplicated). Review of the admission Minimum Data Set, dated [DATE] revealed the resident had a brief interview for mental status score of 15, which indicated intact cognition. The resident had behavior symptoms directed toward others and behavioral symptoms not directed toward others one to three days of the observation period. R11 mobilized with the use of a wheelchair and required substantial/maximal assistance for activities of daily living including sitting to lying down, lying down to sitting, sitting to (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	standing, chair to bed transfers, and toilet transfers. Review of [DATE] Care Area Assessments (CAA) for R11 revealed the Functional Abilities (Self-Care and Mobility) CAA, Behavioral Symptoms CAA, Psychotropic Drug use CAA, Mood State CAA, and Psychosocial Well Being CAAs triggered for further review, but were not further assessed for potential problems to determine care planning decisions and implement effective interventions for his care. Review of the [DATE] hospital referral sheet for admission to the facility revealed R11 had a history of chronic alcohol abuse and a history of drug abuse. The document noted the resident admitted to the hospital for various reasons, including alcohol and substance abuse. The resident was disheveled and unkept and evasive about his last use of substances. R11 reported current drug use at the time of the assessment. The resident's Care Plan initiated on [DATE] lacked any intervention related to the resident's diagnoses of psychoactive substance abuse and stimulant use, which included signs/symptoms, and triggers of possible illegal substance use. The facility further failed to implement any interventions when illegal drug paraphernalia was identified in the resident's room on [DATE] and drug paraphernalia, which contained actual methamphetamine (reported by the nurse on duty) was observed and confiscated on [DATE]. The care plan lacked any indication the resident had a history of cutting his scabs off with a knife. The resident's Care Plan revealed the following interventions: [DATE] – Staff would assist the resident, family, and caregivers to identify strengths, utilize positive coping skills and reinforce them. [DATE] - Behavioral health consults as needed with contracted psychiatric provider. [DATE] – Staff were to monitor/document/report as needed any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harming or trying to harm self, refusing to eat or drink, refusing medications or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. [DATE] - Monitor/record/report to the physician as needed the resident's risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. [DATE] - Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity Review of the [DATE] at 07:25 PM Health Status Note revealed the resident reported developing large blisters to fingers on both hands. The note lacked any further documentation about description of the blisters, investigation into the cause of the blisters, or any intervention related to the blisters. Review of the [DATE] at 01:30 PM Health Status Note revealed the resident had a flat affect, was easily angered, and often refused cares. Subsequent notes lacked any intervention related to the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	resident's affect or behaviors. Review of the [DATE] at 09:48 AM Health Status Note revealed an unidentified Certified Medication Aide reported the resident was cutting off scabs from his skin with a Buck knife and applying alcohol to the areas. The CMA then reported seeing out of facility meds sitting on table. The note lacked any follow up to the medications sitting on the resident's table or the use of the buck knife to cut scabs from his skin. The note further lacked evidence the facility intervened with the non-facility ordered medications or resident's self-harming behaviors. Review of the [DATE] at 01:22 PM IDT [Interdisciplinary Team] Meeting Summary Note revealed the resident received wound care to the bilateral upper and lower extremities caused from self-picking behaviors. The note lacked evidence the team addressed the underlying cause of R11's self-picking behaviors or initiated any interventions outside of the wound care. Review of the [DATE] at 03:25 PM Social Services Progress Notes revealed the resident continued to spend all of his time isolated in his room but had a recent visit from a family member. The note lacked any follow up or intervention related to the resident self-isolating. Review of the [DATE] at 02:14 PM Social Services Progress Notes revealed the writer noted a green tackle box and a red basket on the floor in R11's room with pill bottles [the note lacked description of what the pill bottles contained], lighters, books, and other items scattered on the floor next to them. The writer asked the resident about the mess all over his floor and R11 said he wanted a class of grape juice and then threw a cup towards the window. The writer picked up all of the contents of the boxes along with the boxes and took them to her office. The tackle box was full of supplies to make fishing lures, and the red basket contained a torch, 4 pill bottles (unidentified contents), a red lighter, a large knife, and a black pouch containing a drug pipe. Administrative Staff A was notified of the incident. The note lacked any follow related to the unidentified pill bottles, knifes, torch/lighter and/or drug pipe even though the resident has a history of illegal substance use and self-harm with the use of a knife. Review of the [DATE] at 09:30 PM Incident Note revealed Certified Nurse Aide (CNA) AA approached the nurse writer asking him to check on R11. CNA AA reported the resident's face was extremely red and eyes looked to be pinpoint. Upon assessment the nurse found the resident to be awake and as described by the CNA. Licensed Nurse (LN) W documented he suspected the resident to have ingested an unidentified narcotic substance. LN W indicated the resident had a crack pipe in his possession within the prior two weeks. The LN notified Administrative Staff A of the situation, and she gave permission to search the resident's room. When searching the room CNA AA found a crack pipe and lighter hidden in an eyeglass case. LN W then notified Administrative Staff A of the findings, and she instructed him to notify Consultant Nurse C, who instructed LN W to contact the resident's physician for further direction. The physician instructed LN W to send the resident to the hospital for further evaluation, and the resident refused. The resident stated he would leave the building with law enforcement, but not Emergency Medical Services (EMS). The resident's physician then instructed LN W to notify law enforcement and have the resident arrested. The deputies who arrived on scene stated that due to the resident's medical conditions they could not transport him out of the building but told facility staff to notify them immediately if things were to escalate. The resident's physician then instructed LN W to inform R11 if he did not go to the hospital to get checked out the facility would discharge him, and R11 continued to refuse transport to the hospital. Administrative Staff A was notified of the situation. The resident's record lacked evidence the facility monitored the resident for adverse outcomes after identifying he consumed methamphetamine in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Miscellaneous tab in R11's EHR revealed the resident was seen by a contracted psychiatric provider history of alcohol abuse, manic behavior, anxiety disorder, history of drug abuse, and stimulant use. The plan for the resident was to continue supportive care and antipsychotic medication for each month they visited the resident from 09/2025 to 12/2025. An observation/interview with R11 on [DATE] at 02:50 PM revealed the resident laid in bed in his room with a catheter hanging on his bedside commode to right side of the bed while the resident was on the phone. The resident had several scabs to his left forearm, one to the right forearm. The resident reported staff do not always provide the cares they say they do for him. During an interview on [DATE] at 05:53 PM CMA BB reported there was not always enough staff to attend to resident needs. A confidential interview (date and time withheld to protect anonymity) revealed they did not feel like there were enough staff to monitor and meet the resident's needs. They reported resident checks, assistance, and cares lacked as a result of continued staffing problems. They stated they try to perform the duties assigned to them but could not always get it done and it impacted the residents. The CNA requested anonymity due to fear of retaliation for any concerns brought to facility administration. A confidential interview (date and time withheld to protect anonymity) revealed there were not enough staff to get things done. They reported the only resident who required them to have another staff member go in with them was R11 (the care plan lacked any documentation R11 required two staff to enter the resident's room for any reason). The staff member stated they did not report anything to Administrative Staff B due to fear of retaliation. During an interview with LN W on [DATE] at 06:30 PM revealed on [DATE] dayshift CNAs reported to him that they thought the resident was intoxicated. The LN stated R11was found with a crack pipe two weeks prior. The CNAs working that evening stated the resident did not look right. LN W and the CNAs went to the resident's room to check on him, but played it off by stating they needed to check the resident's blood sugar. When the LN entered the resident's room he stated you could not miss the fact the resident was intoxicated. R11's eyes were red, pupils were pinpoint, and face was very red all over. The resident maintained a dead stare and it was obvious something was definitely not right with him. LN W stated he had studied methamphetamine and other street drugs so was aware of how the narcotic was made and how toxic the substance was, not only to the resident ingesting it, but anyone who would have encountered it. LN W immediately contacted Administrative Staff A for further instruction on what to do. LN W stated the resident denied the use of any drugs and refused to let him search the room so he asked Administrative Staff A if he should/could search the room with reasonable suspicion of drugs/drug paraphernalia. Administrative Staff A gave permission to search the resident's room against his wishes. The LN and CNAs on duty went into the resident's room to search it, but asked the resident again stating they just wanted to ensure his safety and he declined the search. They began searching the resident's room, pulling things out of the room and originally were not finding anything other than the resident's personal belongings. They noticed a black case for eyeglasses and felt it looked out of place so opened it and upon dumping it out a crack pipe with methamphetamine still in it fell out of the case along with a lighter. The LN immediately reported the findings to Administrative Staff A who instructed the LN to call Consultant Nurse C who instructed him to call the resident's physician. The physician gave instructions to notify EMS due to a foreign substance in his system. When EMS entered the room, the resident refused to be seen for evaluation at the hospital. EMS did try to encourage the resident to go with them for evaluation, he refused. Both (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	the LN and EMS instructed the resident they wanted him to get checked out due to his health and were not concerned with act of using the drugs. LN W called the resident's physician again for further instruction and was told to call law enforcement, but they were already on the way due to the EMS call. When law enforcement arrived they stated they could not take the resident due to his underlying medical conditions even though they verified the drug was an illegal substance. LN W was told it would likely just be a misdemeanor offence anyway. LN W stated he was deeply concerned because the drug could cause harm being on the resident's skin or could be accessible to another resident. LN W stated when the pipe was on top of the medication cart it tipped over and the substance inside fell all over the top of the cart, so he put gloves on and cleaned it up. LN W reported to the resident's physician that the resident could not be arrested due to his medical conditions. The physician then stated they were going to use a scare tactic and tell the resident nicely that the resident would be given an involuntary discharge if he was not evaluated at the hospital. The resident continued to refuse treatment and EMS left. LN W stated he did not know the extent of what the resident ingested and again noted the toxic chemicals used in production of the drug. LN W stated he monitored the resident as much as he would let him, but that was it. LN W stated he was not aware of the incident that occurred on [DATE] until after the [DATE], but he wished he would have been notified so he could have monitored the resident more closely during that time. LN W was not aware of any interventions put into place regarding the resident's substance use disorder and the two incidents. LN W reported upon search of the resident's room they found three pairs of scissors, knives and a hammer in the resident's belongings and LN W was not aware of what happened to those items. He stated thank God the resident isn't able to get out of bed on his own or he believed two members of law enforcement could not stop him on the drugs as they are entirely unpredictable. He also worried that if the resident did not have his drug of choice, he would start using other drugs, which make people violent. He was unaware if any education was provided after the incident, further monitoring of the resident, and/or interventions placed to care for R11 with a history of substance use. During an interview with Administrative Staff A at approximately 07:16 PM on [DATE] she reported she was unaware of what happened to the drug paraphernalia and pills located in R11's room on [DATE] and assumed law enforcement took them but also was unaware if law enforcement was notified. Administrative Staff A stated she was unaware of what pills were located in the resident's room and/or how he obtained them. Administrative Staff A was unaware if staff further monitored the resident after he consumed narcotics on [DATE]. - R32 admitted to the facility on [DATE]. R32's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI-an injury to the brain caused by external forces) with loss of consciousness, adult failure to thrive, and other seizure (violent involuntary series of contractions of a group of muscles). R32's admission Minimum Data Set (MDS) dated [DATE], documented R32 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. R1 had no falls since admission. R32's Quarterly MDS dated [DATE], documented a BIMS was not conducted due to R32 being rarely/never understood. R32's Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA) dated [DATE], lacked an analysis of findings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R32's [DATE] Care Plan, revised on [DATE], documented R32 was at risk for falls and injury related to unsafe mobility and impaired safety awareness. R32 demonstrated difficulty with safe bed use and was often noncompliant with requesting assistance due to his cognitive impairment and poor decision-making related to his TBI. The presence of a standard bed frame increased R32's potential for injury if a fall occurred or R32 unsafely transferred from bed. R32 had a fall on [DATE] and [DATE]. The Care Plan documented the following intervention: [DATE]- The staff provided a mattress on R32's floor for safety, comfort, and injury prevention. The care plan did not document interventions after R32's falls on [DATE] and [DATE]. R32's EMR revealed the following: An Incident Note on [DATE] at 07:00 AM, documented the staff heard R32 yelling from the hallway. The staff noted R32 laid on his right side near the [NAME] exit door and he stated he fell trying to pull his pants up. The nurse preformed a head-to-toe assessment, obtained R32's vital signs, and initiated neurological checks. R32 stated he did not hit his head and the staff noted no injuries. An Incident Note on [DATE] at 08:02 AM, documented the nurse notified the director of nursing (DON), Consultant V, and Administrative Staff A, and attempted to notify R32's representative but her voicemail box was full. A Health Status Note on [DATE] at 03:17 PM, documented R32 experienced an unwitnessed fall today at 10:10 AM. The staff noted no injuries and R32 denied pain or hitting his head during the fall. R32 was chronically repetitive, disorganized, and became violent with staff members and other residents when agitated. R32 wandered the halls and appeared anxious. He knocked on doors and attempted to enter other resident's rooms, disturbing them and frightening them. An Incident Note on [DATE] at 02:30 PM, documented the staff reported that R32 fell in the bathroom between two rooms and that his forehead was bleeding. The nurse noted a small, shallow abrasion to his left forehead that measured one centimeter (cm) by 1.5 cm. The nurse applied a clean dressing to R32's forehead and obtained his vital signs. R32 stated he needed to go to the bathroom, and he fell, hitting his forehead on the heater vent on the floor during the self-transfer. The staff assisted R32 into his wheelchair at 02:20 PM, just prior to the fall, in another resident's bathroom. The nurse notified Consultant V, Administrative Nurse B, and R32's representative. R32's neurological checks were within normal limits for him as he was only alerted to self only and had left sided paralysis. An Incident Note on [DATE] at 02:00 PM, documented the facility initiated one-on-one safety supervision with a staff member to maintain continuous visual contact to prevent further risk of harm to self or others at that time. Upon request for fall investigations for R32, the facility provided reports for R32's falls on [DATE] at 07:00 AM and [DATE] at 10:10 AM. The facility did not provide a report for R32's fall on [DATE]. The facility's report for R32's fall on [DATE] at 07:00 AM, documented Licensed Nurse (LN) FF heard R32 yelling from the hallway. LN FF noted R32 laid on his right side near the [NAME] exit door. R32 stated he fell when he tried to pull his pants up. R32 stated he did not hit his head. The report lacked a root cause analysis of the fall. The facility's report for R32's fall on [DATE] at 10:10 AM, documented R32 experienced an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	unwitnessed fall in his bedroom. The report lacked a root cause analysis of the fall. On [DATE] at 01:52 PM, R32 self-propelled in his wheelchair down the hallway. An unidentified female staff member supervised him. On [DATE] at 10:33 AM, R32 self-propelled in his wheelchair down the hallway towards his room. An unidentified female staff member stated to another staff member that R32 wanted to lay down for a bit. On [DATE] at 03:59 PM, Certified Nurse Aide (CNA) N stated if a resident fell, she stayed with the resident and called for help. She stated the nurse did an assessment and asked what the resident was doing or if they hit their head. She stated the staff tried to determine how the resident fell and completed witness statements. CNA N stated they put an intervention into place if they were able to. She stated if new interventions went into place, she did not receive any notification of new interventions. CNA N stated the facility did not have a report sheet and she received updates through word of mouth. On [DATE] at 05:04 PM, LN S stated if a resident fell, she referred to the fall checklist to make sure she completed everything. She stated she assessed the resident, got their account of what happened, looked at environmental factors, obtained their vital signs, and ask staff if they saw what happened. She stated she contacted the provider for direction and notified the resident's family, the administrator, and the DON. LN S stated if the fall was unwitnessed, she asked who last saw the resident and what they were doing. She stated she had the staff fill out witness statements and started neurological checks. LN S stated she put an intervention in place at that time to prevent further falls then let the DON know about the intervention to update the care plan. She stated R32 fell once during an altercation and received a minor laceration. LN S stated he had fallen another time, but she did not know if the care plan had interventions put into place. She stated she expected there to be a fall intervention on the care plan after each fall. On [DATE] at 05:45 PM, Consultant Nurse C stated if a resident fell, she expected staff to notify the charge nurse, and the charge nurse completed an assessment. If the fall was unwitnessed, she expected the nurse to initiate neurological checks then notify the physician and resident's representative after completion of the assessment. Consultant Nurse C stated she would like staff to do a root cause analysis if they had an idea of what caused the fall and put in an intervention immediately after the fall. She stated she expected every fall to have an intervention put into place and the charge nurses should be updating the care plan. The facility's Fall Prevention Program policy, last revised [DATE], directed when a resident experienced a fall, the facility assessed the resident, completed a post-fall assessment, completed an incident report, notified the physician and family, reviewed the resident's care plan and updated as indicated, documented all assessments and actions, and obtained witness statements in the case of injury. - R16 admitted to the facility on [DATE]. R16's Electronic Medical Record (EMR) documented diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) and pain in left hip. R16's admission Minimum Data Set (MDS) dated [DATE], documented R16 had a Brief Interview for (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. R16 had no impairment in her upper and lower extremities. R16 used a wheelchair, and she required staff supervision or touching assistance with standing and transfers. R16 had no falls since admission. R16's Quarterly MDS dated [DATE], documented R16 had a BIMS score of 14 which indicated intact cognition. R16 had no impairment in her upper and lower extremities. R16 used a walker and a wheelchair and required substantial to maximal staff assistance with standing and transfers. R16 had one noninjury fall since the last assessment. R16's Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated [DATE], lacked an analysis of findings. R16's [DATE] Care Plan revised on [DATE], documented had an actual fall with unsteady gait. The Care Plan documented the following interventions: [DATE]- The staff continued R16's interventions on the at-risk plan. [DATE]- For no apparent acute injuries, the staff determined and addressed causative factors of R16's fall. [DATE]- The staff notified R16's legal guardian of any falls or updates to her fall risk. [DATE]- The pharmacy consulted to evaluate R16's medications. [DATE]- Physical therapy consulted for strength and mobility for R16. R16's Care Plan did not address her ADL status including transfers and mobility. On [DATE] at 02:11 PM, R16 sat in a chair in the day area with her walker beside her. Activities Director E walked up and asked R16 if she wanted to go into the dining room for happy hour. Licensed Nurse (LN) S and Activities Director E got on either side of R16 and each placed one of their arms under her armpit and helped R16 stand up from the chair. R16 walked into the dining room with her walker. On [DATE] at 03:59 PM, Certified Nurse Aide (CNA) N stated she was unsure if there was a report sheet or Kardex (nursing tool that gives a brief overview of the care needs of each resident) on how to transfer a resident or to use a gait belt. She stated she kept resident safe during transfers by using a gait belt. CNA N stated if she had to put her hands on a resident when standing them up, she used a gait belt. She stated staff should not hook their arms under R16's arms to help her stand up. On [DATE] at 05:04 PM, LN S stated staff knew a resident's ADL status from the EMR. She stated if she helped a resident stand, she used a gait belt. She stated R16 used to transfer herself but the chairs in the day area were so low that she needed someone to help her stand up. LN S stated staff should put a gait belt around R16 as a point of assistance when standing her up, not using their arms under R16's arms. On [DATE] at 05:45 PM, Consultant Nurse C stated staff knew how to care for residents through their care plan and they should know how to access them. She stated care plans should be as individualized as possible to provide the best care, including ADLs and how a resident transferred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Consultant Nurse C stated she expected staff to use a gait belt for a safe transfer and to not use under the resident's arms to transfer. The facility's Safe Resident Handling Transfers Policy dated [DATE], directed the facility used gait belts with residents that could not independently ambulate or transfer for the purpose of safety.

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Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 34 residents. Based on observation, interview, and record review the facility lacked a system for records of receipt through disposition of all controlled medications, in sufficient detail to enable accurate reconciliation and ensure drug records were in order. The facility also failed to ensure a record system to account for all controlled medication which was maintained and periodically reconciled. The facility pharmacy lacked onsite presence in the facility to assist in the destruction of controlled narcotic substances from February 2025 until [DATE]. The facility had a locked cabinet inside the medication room used for narcotic medications awaiting destruction. The administrator did not know who had the key for the locked cabinet and required maintenance staff to cut the lock off of the cabinet on [DATE], revealing the cabinet was full of narcotic controlled medications dating back to 2024. Through record review the facility could not account for 49 separate narcotic prescriptions, of an unknown quantity each, affecting 22 current and discharged residents.The pharmacy did not identify the increased use of e-kit narcotics used, increased frequent changes to narcotic prescriptions, and lack of destruction of the numerous narcotic medications delivered, or the lack of a facility system in place for the accurate accounting of controlled substances to include PRN and discontinued narcotic medication. On [DATE] review of resident chart revealed the facility did not have her hydrocodone and had to access the e-kit twice to provide pain medication for the residentsThe lack of pharmacy services, procedures, and records placed all residents who received controlled narcotic medications in immediate jeopardy and at risk for unrelieved pain, discomfort, death, and the risk to the resident population which included a history of Substance Use Disorder.The facility Administrator was notified of the Immediate Jeopardy (IJ) on [DATE] at 1:18 PM and remain ongoing.Findings included:- Review of a complaint allegation regarding drug diversion identified the Alleged Perpetrator (AP) as Administrative Nurse B. The allegation included pictures of numerous resident medication cards (bubble pack cards) for as needed (PRN) narcotic medications, with the prescription information label including resident specific prescriptions and information which included: resident name, date of birth , medication order, pharmacy information, and facility information. Most of the pictures displayed empty popped bubble cards of narcotic medication, indicating no medication in the cards. Observation of the pictures and observations onsite at the facility indicated the pictures were taken outside of the facility. On [DATE] at approximately 12:30 PM, the state surveyor informed Administrative Staff A of the allegation against Administrative Nurse B and the allegation included pictures of the facility medication cards (bubble pack cards) and included resident prescription information on them. Administrative Staff A did not know who had the key to the narcotic destruction box. An onsite observation on [DATE] revealed the facility had one medication room with one narcotic destruction box, which was locked. Inquiry revealed most direct care and licensed nursing staff did not know who had the key to the narcotic destruction box, but most assumed Administrative Nurse B had the key.Review of an allegation of drug diversion included over a dozen photos of numerous controlled narcotic medication bubble packs and narcotic count sheets. One photo included a narcotic count sheet indicating all 88 oxycodone tablets should be in the blister pack and another photo had the matching prescription number on the utilized blister pack, with at least 10 empty slots. The investigation the facility provided on [DATE] revealed numerous narcotic medications prescriptions in an unknown quantity for each, that the facility could not reconcile. The investigation revealed the following number of controlled medication prescriptions, of an unknown quantity for each:1-Fentanyl transdermal patch 72 hour, 50mcg/hour2-Hydrocodone-Acetaminophen Oral Tablet 5/325mg1-Hydrocodone-Acetaminophen Oral Tablet 7.5/325mg1-Tramadol 25mg4-Tramadol 50 mg1-hydromorphone HCL oral tablet 8mg2-hydromophone HCL Oral Liquid 1mg/ml6- Lorazepam Oral Tablet 0.5mg2-clonazepam oral tablet 1mg1-clonazepam oral tablet (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	0.5mg3-Morphine Sulfate Oral Solution 20mg/5mL1-Morphine Sulfate Concentrate Solution 20mg/mL1-Morphine Sulfate Oral tablet 15mg2- Morphine Sulfate Oral tablet 30mg1-Morphine Sulfate Extended Release oral tablet 15 mg1-Morphine Sulfate Extended Release oral tablet 30 mg1-oxycodone HCL oral tablet 20 mg3-oxycodone HCL oral tablet 10 mg12-oxycodone HCL oral tablet 5 mg2-Pregabalin Oral Capsule 50 mg1-Ativan Injection Solution 2 mg/mLFurther review of the [DATE] facility provided investigation revealed the facility did not find discrepancies with current narcotic medications and included current narcotic count sheets and scanned copies of the associated controlled medication. However, surveyor review revealed several discrepancies between the information recorded on the narcotic count sheets and the electronic medication administration record (to include administrations recorded on count sheet, but not recorded in the eMAR), and discrepancies in the liquid narcotic medications to include: R6's Morphine Sulphate 100 mg per 5 ml narcotic sign out sheet revealed on [DATE] at 08:00AM the LN documented the Amount on Hand as 21.25 ml, when the prior line indicated the Remaining amount as 21.75 ml. LN then documented the Amount Given as 0.25 and Amount Remaining as 21.00, which is a discrepancy of 0.5 ml not identified in the facility submitted investigation. R32's Lorazepam 2 mg per ml liquid concentrate, administered in 0.25 ml dose every 6 hours as needed, narcotic sign out sheet had a handwritten notation to the right of the medication information label noting: Order [change] [DATE] give 0.50 ml, (every 6 hours PRN had a line drawn strikethrough) every 4 hours PRN. The narcotic count sheet had a ?count corrected - spilled' notation with an illegible signature and date, located between the [DATE] and [DATE] sign-out lines, and indicated a 3.75 ml ?spill' of the medication and no associated progress note. R32's Lorazepam 2 mg per ml liquid concentrate, administered in 0.5 ml dose every 4 hours as needed revealed on [DATE] at 12:30 PM LN FF documented 0.5 ml as Amount Given and the Amount Remaining as 26.5 ml with a drawn strikethrough on the line and notated ?ref'. On [DATE] at 01:30 PM LN FF documented 0.5 ml as Amount Given and the Amount Remaining as 26.0 ml with a drawn strikethrough on the line and notated ?ref'. No other administrations or notations were listed after this line. On [DATE] at 04:27 PM, Certified Medication Aide (CMA) R stated the facility received shipments from the pharmacy just about daily. CMA R stated when the narcotic count sheets were taken out of the narcotic count book, they were filed in a folder in the nurse's office. CMA R stated when the folder became full the narcotic count sheets were pulled from the folder and went to Administrative Nurse B. During an interview with Consultant Pharmacist (CP) EE on [DATE] at 03:55 PM, she stated she just took over in November [2025]. She stated she is the pharmacist the facility should use to destroy narcotic medications. CP EE stated she sent an email to the facility on [DATE]th announcing she was taking over as the new pharmacy consultant for the facility. She stated she reached out to Administrative Staff A and Administrative Nurse B on [DATE] and [DATE] to schedule a time to destroy narcotic medications with the facility and neither staff member responded to her emails. CP EE stated in the December email she stated she would be in the area and reminded them they needed to set up a drug destruction, but no one responded. She stated she felt like she was emailing into a void, since no one from the facility has responded to any of her emails. CP EE stated the facility is expected to wait for CP EE to be there to destroy medication and said she is supposed to sign the medication forms, which she said would also be signed by Administrative Staff A and Administrative Nurse B. CP EE said she was not sure Administrative Staff A and Administrative Nurse B knew they needed to wait for CP EE to destroy narcotic medication. She stated the prior consultant pharmacist informed her the facility had not been receptive to setting up times for visits. CP EE was not sure of the last narcotic destruction date. During an interview with Administrative Nurse B on [DATE] at 10:07 AM revealed the facility had a new pharmacist, who she thought took over in October. Administrative Nurse B said she never met the prior consultant pharmacist and she never came to the facility. Administrative Nurse B stated she got emails from her, but never saw her come here, and stated she then got an email from the new CP announcing she was taking over. Administrative Nurse B stated she had not met either of them. During an interview with (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administrative Nurse B on [DATE] at 11:02 AM she stated if the resident changed or discontinued a medication the narcotic card would be removed from the medication cart. Administrative Nurse B stated a few years ago an agency nurse took medications and count sheets, so the facility counts the cards to keep track of the number of cards. Administrative Nurse B said the staff count the number of cards at the beginning of each shift and the card count went to her (Administrative Nurse B). Administrative Nurse B stated she kept a book and had them all filed in a binder, count sheet and card count sheets, but they were in the process of being sorted and organized and she may not have some of them, they are not organized. Administrative Nurse B said if there were remaining narcotic medications, they went in the cabinet in the medication room and stated the policy required two licensed nurses, or a CMA and a nurse, or a pharmacist combination of those people, who can destroy them. Administrative Nurse B stated some residents take bubble packs home with them, but have to get approval for it, and hospice would count and take with them. Administrative Nurse B stated if the resident was not on hospice and they did not take them home, the narcotic medication went in the narcotic destruction cabinet. Administrative Nurse B said she did not destroy medications and if there was a discrepancy, she conducted an investigation. She stated she was supposed to have the key to the narcotic destruction cabinet but she needed to look in her desk. Administrative Nurse B then stated the prior Director of Nursing (DON) had a key for a while, but she left in June or July and it was an issue trying to get stuff back from her. Administrative Nurse B said she began in March or early April and Administrative Staff A began in February 2025. Administrative Nurse B said the prior DON had been gone since August or September maybe, but she was not sure. Administrative Nurse B said they had a disgruntled employee who was a licensed nurse but worked in medical records and may have had a key to the narcotic destruction box. Administrative Nurse B said she has not destroyed any medication since she started working in the facility (approximately [DATE]) and said she was not supposed to destroy medications and not sure why the other two staff members might have had the key. Administrative Nurse B said when the licensed nurse medical records staff member left employment the facility found a lot of things missing, but not narcotics. Administrative Nurse B said she did not know what happed to the narcotic destruction box key and said she knew some medications were in there but not sure what medications. Administrative Nurse B then said that's why I asked maintenance to cut off the lock. I don't know what is in there and said she asked maintenance to cut of the lock (indicated prior to today). During an interview on [DATE] at 01:47 PM, Maintenance Staff J stated the key was not something he messed with and he assumed the nurses or DON had it. Maintenance Staff J said he did not track the key and then stated no one ever asked him to cut the lock off of the narcotic destruction cabinet or had informed him the key was lost. Maintenance Staff J said he did not know there was an issue with the narcotic destruction box. During the investigation, the surveyor asked for the count sheet for R36's oxycodone (narcotic pain medication) or evidence the resident took the medication home, since these were identifiable in the complaint photos. The facility could not provide a copy of the count sheet for the medication and it was requested twice of Administrative Staff A, twice of Administrative Nurse B, and once of Licensed Nurse S. During an interview on [DATE] at 01:57 PM Administrative Staff A stated the facility did not have the count sheets for R36's oxycodone and did not have evidence that R36 took it home. Administrative Staff A stated she could not find it and it did not look like the facility had it. During an interview on [DATE] PM at 12:06 PM, Administrative Staff A stated she has never been in the facility when the narcotic medications were destroyed, stated she was not a nurse, and she does not have anything to do with medications. Administrative Staff A stated she never saw pharmacy in the facility to destroy narcotic medications and said Administrative Nurse B should have the narcotic destruction key. Administrative Staff A stated she had not asked Administrative Nurse B if she had key, but she should have it and thought she did. She further stated per the facility policy, narcotic medication destruction required a licensed nurse or nurse and certified medication aide or pharmacist. Administrative Staff A stated it could be an issue with Administrative Nurse B having a key and all count sheets going to her, as a (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	single point. Administrative Staff A stated as far as she knew Administrative Nurse B had the key and she did not know who else would have it. Administrative Staff A stated as far as she knew the pharmacy had not been out, but said they may not check in with her when they do since she does not do anything with medications, but had never seen them. Administrative Staff A stated the pharmacist sent out pharmacy recommendations once a month, so she was in contact with them and stated there absolutely should be a record of what was destroyed, but was not positive if or where the record could be. She stated there should be a book of record of what was destroyed and she was not sure if it was at the nurses station or in her office, but there should be a record of it. Administrative Staff A stated she could see how it could be an issue with only Administrative Nurse B as the staff member with the key to the narcotic destruction cabinet and all counts sheet going to Administrative Nurse B. During an interview on [DATE] at 02:27 PM Administrative Staff A she was not sure about the key and no one she talked to knew where it was or knew who had it. During an interview on [DATE] at 03:27 PM Administrative Staff A stated they were going to cut the lock off and place a new lock to the narcotic destruction box and record new sheets of what was in the cabinet. Administrative Staff A stated the nursing supervisor was coming up with process and they would have the pharmacist come in on a regular basis, but for now Administrative Staff A would hang on to the only key to the narcotic destruction cabinet. Administrative Staff A stated that anything that needed to be destroyed would now be destroyed immediately. Administrative Staff A clarified the facility was doing an audit right now, then came back and said they would not destroy but will audit whatever is inside of the destruction cabinet. During an interview on [DATE] at 04:25 PM Administrative Staff A stated they finished the audit of current medications and found no discrepancies. She stated the facility would cut the lock off of the cabinet to see what was inside, place a new lock, and she would keep the key. She said it was not done yet, but it would be. During an interview on [DATE] at 07:39 PM Administrative Staff A stated it looked like the pharmacy did email herself and Administrative Nurse B, and Administrative Staff A said she never opened them, as she thought Administrative Nurse B opened them. Administrative Staff A stated the emails were encrypted so she could not see what was in them. During an interview on [DATE] at 01:42 PM Administrative Staff A stated the facility did not have all of the delivery sheets from the pharmacy to line up with all of the discontinued narcotic medications since [DATE]. Administrative Staff A stated she had to contact the pharmacy to have that list sent and stated it might take a while to get it. She stated right now she was not sure if everything on the list made it to the facility. On [DATE] at 03:25 PM Administrative Staff A stated she could not find any record of pharmacy destruction sheets and could not find any facility medication destruction sheets. Administrative Staff A stated she had not seen anyone destroy medications since she started in February 2025. During an interview with Licensed Nurse T on [DATE] at 10:18 AM revealed when the narcotic medication bubble cards were empty, the staff tore off and shredded the resident label. LN T said the count sheets were taken out monthly and given to Administrative Nurse B. LN T said the medication count sheets and the narcotic count sheets are separated, go into a folder in the nurse's office, and then to Administrative Nurse B. LN T stated discontinued medications to destroy went into the cabinet with the lock and stated the nurses did not get in the cabinet. LN T said she thought Administrative Nurse B had the key to that cabinet. During an interview on [DATE] at 10:19 AM, Licensed Nurse S revealed when medication cards were empty, staff took the narcotic sign out sheet signs and put them in the completed narcotic sheet folder in nurse's office on the door. She said the staff then tore the label off and shredded them. LN S stated if a resident passed away or moved out and did not take the narcotics with them, the staff wrapped the narcotic in the count sheet and made sure the pills match the sheet, then counted the cards and pills. LN S said about 2 years ago an agency nurse took sheets with cards and the staff had no way to know the medications were missing initially, so we started counting cars as well when we count medications. She said card count sheets were done every day and is a running list. LN S said if someone had hydrocodone prescribed, they would take it to the medication aide, count medication, (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	place it in the narcotic box, and the card would get added to the card count sheet. LN S said when the cart count sheets were full, they were replaced with a new one, updated the total, and the card count sheet went to Administrative Nurse B. LN S stated discontinued medications to destroy were put in the cabinet in the medication room, which has a slot on the cabinet door and a lock on it. She said the staff slide the medication card with the count sheet into the cabinet. LN S said no one had access to unlock the cabinet, aside from Administrative Nurse B. She said pharmacy could destroy medication with the nurse and assumed there would be a record of medications that were destroyed. LN S said Administrative Nurse B probably had that and Administrative Nurse B can access the box/cabinet. LN S said someone would come in every three months to destroy the medication, but not sure how often the pharmacy should come in. She said sometimes hospice came in to destroy or took medications with them. LN S said the floor nurse did not destroy medications and the pharmacist does not come in. During an interview on [DATE] at 07:40 PM LN S said she talked to Administrative Nurse B about the narcotic destruction key and Administrative Nurse B told her she did not know who had it. LN S said Administrative Nurse B told her some things may be missing from the cabinet because another nurse may have accessed it. LN S said the former employee Administrative Nurse B mentioned would not have had that key, since that person was medical records. The facility provided a printed list of narcotic medications which listed the resident name, order, directions, category, status, started date, end date, and revision date. The oldest ?end date' range on the list was from [DATE] to [DATE]. The copy of the 9-page document had hand written numbers to the left of each medication from 1 to 107, and written outcome notes on some of the medication lines such as: kept, dose changed, 0 here, sent home, in cabinet, probably not sent, or maybe didn't get sent. Review of the printed list of medications revealed 39 medications had 0 here written on them, 2 did not contain written outcome notes (one was for a resident who left against medical advice and the other for a resident who died), and 9 indicated the medications were sent with the resident. The record lacked evidence for 5 of the medications that they were sent with the resident and the other 4 were for residents that had died. During an interview on [DATE] at 03:21 PM, LN S revealed a 0 here written on the facility provided list of 107 medications, indicated it meant not here and they could not find the medication in the building. LN S stated they should be there, but they cannot find the medication, as they are not in the cabinet or medication carts. LN S said they knew there was no pharmacy destruction on record for the time period of the medications listed and should otherwise be in the building. She did state they were waiting for the pharmacy delivery sheets to confirm the ones that were delivered to make sure. Otherwise, if the sheets show they were sent, they should have them and do not. During an observation in the medication room on [DATE] at 05:30 PM, Maintenance Staff J cut the lock of the medication destruction cabinet in the presence of Administrative Staff A and LN S, and replaced the lock with a new one. Inside the medication destruction cabinet were stacks of medication cards with count sheets attached to them. The medication destruction cabinet had a slot on the right side and was made of wood. The slot on the side was not large enough for the boxes with morphine/Ativan/liquid meds in them to fit through, which were inside the cabinet. Some boxes with bottles were found inside the cabinet. A large metal box sat inside and at the bottom of the cabinet with two locks on it-- and the surveyor could not visualize the contents. LN S and Administrative Staff A said they did not know what was in the metal box and stated no one had keys. LN S attempted to unlock the box using all keys on the nurse key ring, button worked. LN S and Administrative Staff A stated it was likely left when the previous company owned the facility, but they are not sure how long it was in there. Per LN S and Administrative Staff A it was a metal sharps style bin and contained what appeared to be empty bottles of Ativan and Morphine and unable to visualize the resident labels on the bottle as only viewable from a slot on top of the bin. Appeared to be morphine and lorazepam bottle (6 morphine, 2 lorazepam, and 1 other bottle unable to discern). Review of the facility provided interview notes, emailed on [DATE], revealed a typed and unsigned document titled Investigation Interview Notes and denoted the following responses from interviewee: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety 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 34 residents with 14 in the sample. Based on observation, interview, and record review the facility failed to implement and maintain an effective infection prevention and control program in accordance with a facility assessment, regulatory requirements, and professional standards of practice. Upon entrance to the facility resident rooms had clothing piled on side tables and on the floors, trash cans in resident rooms were full, and staff present failed to maintain infection control practices when transporting laundry, trash, and multi-resident use medical equipment. The facility further failed to implement enhanced barrier precautions (EBP) for residents at risk for the transmission of infectious agents through wounds, catheter use, and/or other medical devices. The facility lacked evidence they tracked the spread of infection within the facility, assessed residents for the infectious organisms, and implemented interventions to prevent further spread of infections. Review of Resident's (R)11, R9, and R7's electronic health records related to infection control and prevention revealed residents had various infections present, admitted to the hospital for intravenous (IV) antibiotics, had amputation of limb due to osteomyelitis and arthritic sepsis, admitted to an intensive care unit for treatment of sepsis, and were diagnosed with multidrug resistant organisms without an effective EBP program. The facility lacked evidence they maintained a water maintenance program to prevent the spread of waterborne pathogens. These systemic failures placed all residents in immediate jeopardy as they created the likelihood for the transmission of infectious agents and subsequent infection and caused actual severe infection with significant outcomes or placed the residents at risk for serious harm, or death.The facility Administrator was notified of the Immediate Jeopardy (IJ) on 1/16/2026 at 1:18 PM and remain ongoing. Findings included:- The facility identified Administrative Nurse B as the current Infection Preventionist. The facility failed to provide evidence Administrative Staff B was qualified to fill the role by education, training, experience or certification. Review of the Facility Assessment Tool dated 11/18/25 revealed the facility was licensed for 45 beds, with an average census of 32 residents. The facility identified their common diagnoses related to infectious disease as skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections, infections with multi-drug-resistant organisms, septicemia, viral hepatitis, clostridium difficile, influenza, and scabies. The facility identified an average range/number of isolation/quarantine residents with active infection as one to three. The facility noted they would need to provide residents with identification and containment of infections and prevention of infections. The assessment contained a section for the facility to evaluate their infection prevention and control program, which included effective systems for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals that follow national standards, but the assessment lacked any evaluation, review, or development of their infection control program. Upon entrance to the building on 01/11/26 at approximately 01:45 PM the facility had a very strong smell of urine that started in the entry before going into the commons area of the facility and stayed throughout the tour. Continued observation on 01/11/26 during initial resident screening observations revealed multiple rooms on the west hall were noted with clothes present on the floor and the trash to be full. The hallway contained two mechanical lifts which had dust and debris present on the bases. Staff removed the lifts and took them throughout the facility with no observations of cleaning the lifts. One room on the west hall had a particularly large amount of clothing noted on the floor next to the closet, which wrapped around the bottom of a large white fan present in the room and strung out into the walking path of the floor. The clothes noted on the floor included what appeared to be multiple shirts, pants, and towels. The smell of urine remained during the observation of the west hall. Staff present entered the room for an unknown reason and did not pick up or address the clothing that continued to lay on the floor. One room, which belonged to Resident (R) 11 had a sign on the door indicating staff were to take (continued on next page)

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Continued observation during the initial tour of the facility on 01/11/26 revealed the east hall lacked any additional notifications of residents requiring EBP or PPE and/or PPE placed along the hall for staff to utilize for the prevention of spread of infectious organisms. Rags and/or clothing were noted hanging over the handrails, the cloth items were rigid and appeared to have been wet and dried in that location as they maintained their shape when staff lifted and removed from the area. Multiple resident rooms on the east hall contained clothing on the floor and piled on their bedside tables. Between approximately 02:06 PM and 02:13 PM Certified Nurse Aide (CNA) N started going to resident rooms and gathering the clothing items, as she exited resident rooms she was noted carrying the piles of clothing with her bare hands, pressed against her body. CNA N returned to work with the same clothing on. CNA U then exited a room on the east hall with a mechanical lift, parked the lift in the solarium area of the facility, and failed to clean the lift at any time during the observation. The lift had various footprints visible in a dusty film present over the base. At approximately 02:22 PM Hospitality Aide O took a bag, which appeared to be trash or clothing from one room into another and a short time later left carrying the bag that entered both residents' rooms through commons area to dispose of the bag out of site. At approximately 02:51 PM additional staff started arriving and continued to pick up laundry from resident rooms, including their floors. At approximately 05:16 PM on 01/11/12 drawers containing PPE now sat outside of five additional resident rooms with signs on corresponding doors indicating a resident in the room required EBP. One room on the east hall had a EBP sign on the door, with no EBP present, but looking down and across the hall there was a drawer set containing PPE located in the area between the beauty shop, bookshelf, and other resident rooms. Review of resident electronic health records regarding infections from June 2025 to January 2026 revealed the following: During an interview on 01/11/26 at 05:53 PM with Certified Medication Aide (CMA) BB she stated the facility was often short staffed. She reported when the facility was short staffed, care things were missed, like checking and showering residents. CMA BB stated before today the facility only had one resident who required PPE, including gown, mask, and gloves with cares due to an infection, but reported she was just told staff needed to wear the same PPE for emptying catheters and for residents with wounds. CMA BB reported if a resident had MRSA that was typically the reason staff were instructed to use gowns with resident cares before today (01/11/26). CMA BB also verified the additional PPE and EBP signs placed on both the east and west units after the initial tour were just placed today (01/11/26). During all observations of transport and use of mechanical lifts on 01/11/26 staff failed to clean them between use on multiple residents and transported them throughout the building. During all observation of transport and use of mechanical lifts on 01/12/26 revealed staff failed to clean them between use on multiple residents and transported them throughout the building. During an observation at 10:05 AM on 01/12/26 Certified Medication Aide R came out of R14's room with the resident carrying a clear plastic trash bag with a visibly soiled brief, which appeared to contain a moderate amount of feces. CMA R carried the knotted bag down the hallway while standing by with the resident. The bag swung into open doors along the side of the hallway and as she walked she held the handrails with the thin plastic bag dragging along the wooden/warn handrails. As the bad scraped along the handrails it also hit portions of the wall. CMA R would then switch hands, swing the bag out into the hallway and resume rubbing the bag along the handrails, until she deposited it into a soiled (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. The facility census totaled 34 with 14 sampled and one reviewed for change in condition. Based on observation, interview, and record review the facility failed to ensure staff monitored, educated, and documented effectiveness of treatments regarding a change in condition for Resident (R)9. On 08/23/25, while still on antibiotics for cellulitis (skin infection caused by bacteria) the resident had a change in mental status, refused transport to the hospital, and the facility failed to document continued monitoring of the residents change in status. The facility further failed to document any education provided or reapproach provided after the resident's refusal to be seen. On 09/05/25 the facility notified the resident's provider the resident refused labs the prior day, with no follow up to the resident's refusal documented, no attempts to reapproach the resident, no education provided on the seriousness of obtaining the lab and/or additional monitoring of the resident. On 09/09/25 the resident asked to be transported to the hospital due to pain in the left lower extremity. While at the hospital the resident was diagnosed with extensive infection throughout the left lower extremity and ultimately experienced actual harm when his left lower extremity required amputation. Upon arrival back to the facility the facility failed to implement wound care and days later the resident readmitted to the hospital for treatment of further infection to the residual stump. Findings included:- Review of R9?s diagnoses in the electronic health record (EHR) revealed the resident had peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), acquired absence of left leg below knee, cellulitis (bacterial infection of the skin) of unspecified part of limb, complete traumatic amputation at level between knee and ankle, right lower leg. Review of the 07/15/25 Quarterly Minimum Data Set (MDS) assessment revealed the resident had a brief interview for mental status (BIMS) score of 10, which indicated moderately impaired cognition. The resident rejected cares one to three days of the observation period. The resident had impairment on both sides of his lower extremities. R9 required partial/moderate assistance from staff for toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, and toilet transfers. The resident had a pressure injury (PI) and required a formal assessment for risk of pressure ulcer development. The resident had had one or more unhealed pressure injuries and a risk for pressure ulcer development. R9 had one stage three pressure injury, which was not present upon admission/entry or re-entry, and he received care for that PI. Review of the 09/09/25 Discharge MDS revealed the resident had no pressure injuries. Review of the 10/08/25 Annual MDS assessment revealed the resident had a BIMS of 12, which indicated moderately impaired cognition. The resident had rejection of cares, which occurred one to three days of the lookback period. R9 now required substantial/maximal assistance with toileting, showering, lower body dressing, and total dependence for putting on socks. The resident had no pressure injuries, other wounds, or skin problems identified on the assessment. Review of the 10/08/25 Care Area Assessments (CAA) revealed the following:The Functional Abilities (Self-Care and Mobility) CAA from the EHR revealed the resident demonstrated limitations in functional abilities as noted on the MDS. The resident required assistance with activities of daily living (ADLs) including bathing, dressing, toileting, transfers, and mobility. Cognitive status and/or physical conditions impacted the resident's independence. The CAA indicated the resident may be at risk for further decline in function without appropriate support and interventions. The CAA lacked documentation the resident recently underwent an amputation of the left lower extremity and/or associated changes to his ADL status. Review of the resident's 10/18/24 Care Plan revealed the following interventions:11/12/24- The resident had the potential to be verbally aggressive (yelling at staff) related to ineffective coping skills.11/12/24 - Staff would administer medications as ordered and monitor/document for side effects and effectiveness.11/12/24 - Staff would analyze key times, places, circumstances, triggers, and what de-escalated behavior and document. 11/12/24 - Staff (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	would assess and anticipate the resident's needs, including food, thirst. toileting needs, comfort level, body positioning, pain, and etc.11/12/24 - Staff were directed when the resident became agitated, they would intervene before the agitation escalated. Staff were instructed to guide the resident away from the source of distress, engage calmly in conversation and if R9's response was aggressive, staff were to walk calmly away, and approach the resident later. 11/12/24 - (Related to the resident's diabetes mellitus) Staff were to monitor/document/report as needed any signs/symptoms of infection to any open areas including redness, pain, heat, swelling or pus formation. 04/18/25 - The resident often refused care, staff were to approach him in a calm, but direct manner to assist resident with hygiene, bathing, and other activities of daily living the resident potentially required assistance with. The resident's care plan lacked direction to staff if the resident continued to refuse cares including documentation of the refusal, and/or refusals of skin assessments, wound assessments, or treatments. The care plan further lacked interventions related to the resident's cellulitis of the lower extremity identified on 08/21/25. After the resident's left lower extremity amputation, the following interventions were added to the resident's plan of care, along with other associated interventions:09/18/25 - Staff were made aware R9 had a potential for behavior problem related to the loss of his other foot. Interventions for skin integrity, wound management, and infection were placed on the resident's plan of care on 10/20/25, however were resolved the same day. 11/21/25 (approximately two months after the resident's amputation of the left lower extremity) - Staff would know the resident was resistive to cares.11/21/25 - Staff were directed to allow the resident to make decisions about treatment regime, to provide sense of control.11/21/25 - Staff would praise the resident when his behavior was appropriate. 01/12/26- Staff would know the resident required enhanced barrier precautions for wounds. (The resident's care plan lacked evidence staff implemented EBP for R9 until 01/12/26 even though the resident had a history impaired skin integrity including pressure injuries and the amputation of a limb.) 01/13/26 - Staff would know the resident would refuse wound care to his incision site. Staff were to encourage the resident to allow care to the site. Review of R9 ?s Physician Orders in the electronic health record revealed the resident received the following orders to treat cellulitis:Ceftriaxone Sodium (antibiotic utilized for severe infection) Injection Solution Reconstituted one Gram for cellulitis intramuscularly ordered on 08/21/25 and completed 08/22/25Cephalexin (antibiotic) 500 milligrams by mouth three times a day related to cellulitis of the unspecified part of the limb for seven days started on 08/21/25 and completed 08/28/25. R9's EHR record lacked evidence the facility monitored the effectiveness of the antibiotics administered on 08/21/25 and/or the resident's skin for signs or symptoms of cellulitis. The 08/23/25 skin check for R9 lacked evidence the facility monitored the resident for cellulitis or any other significant changes at this time. No skin issues related to the infection were identified and/or monitoring for changes with the resident skin or effected extremities. R9's 08/25/25 at 06:08 AM Progress Note revealed the resident had altered mental status and was coughing. He did not know where he was at and refused cares. A subsequent note revealed the resident refused admission to the hospital and the resident's provider ordered labs to be drawn the next day. Review of the EHR lacked any additional monitoring put in place or follow up to the resident's change in status. Review of the EHR lacked evidence the facility attempted to or drew the ordered labs the next day. R9's progress notes lacked evidence the facility continued to monitor the resident's change in status, cough, antibiotic completion on 08/28/25, or cellulitis until 09/05/25 when the resident's provider was notified, he refused labs the prior day 09/04/25. The record continued to lack evidence the facility monitored the resident for follow up of the effectiveness of the antibiotic prescribed to treat cellulitis. The resident's care plan lacked indication the resident required antibiotics for cellulitis and/or instruction for the staff to further monitor the resident. On 09/09/25 R9 requested to be sent to the hospital due to severe foot pain. The resident's record lacked evidence the facility monitored the resident's left lower extremity, even though he recently had cellulitis, had a history of pressure injuries to the foot, and had a diagnosis of diabetes mellitus. Review of the 09/09/25 Magnetic (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resonance Imaging (MRI) of the left ankle for R9 revealed the resident had extensive infection involving the bones and soft tissues of the midfoot, hindfoot, and ankle. Osteomyelitis (serious bone infection) involving the (bones in the foot) metatarsal bases, midfoot bones, anterior talus (bone connecting the leg to the foot) and calcaneus (largest bone of the foot). The resident had septic tenosynovitis (serious bacterial or fungal infection of the tendon sheath) and potentially had septic arthritis (infection that spreads to a joint, causing inflammation). The microbiology report revealed blood cultures dated 09/09/25 revealed MRSA was detected. The resident's EHR lacked any documentation the resident returned from the hospital and/or experienced an amputation of the left lower extremity on 09/11/26. The resident's record lacked evidence staff assessed, documented and/or placed interventions related to the amputation. The EHR lacked evidence the facility monitored the resident upon his initial return from the hospital. Review of the 09/17/25 Hospital Discharge Summary revealed R9 admitted back to the hospital with MRSA Bacteremia. The resident admitted to the hospital with left lower extremity cellulitis and septic arthritis status post below the knee amputation on 09/11/26 and required IV antibiotics. Review of the September 2025 Treatment Record revealed documentation for staff to clean incision site on the left leg with saline, pat dry, apply gauze dressing, change daily every day shift for incision site that started on 09/23/25, approximately 5 days after the 09/17/25 date that most medications/treatments resumed after the resident returned from the hospital. On 11/25/25 (two months after the resident's left limb amputation)- the facility noted a problem in the care plan with no interventions or directions to staff, which indicated the resident had impaired mobility related to bilateral lower extremity amputations as evidenced by inability to bear weight, inability to stand, and requirement for total mechanical lift assistance for all transfers with the assistance of two certified nursing staff members. The resident had wounds present at various times since the prior annual survey on 04/16/25 and lacked any indication he required EBP until 01/12/26. An interview with Certified Nurse's Aide (CNA) N on 01/14/26 at 03:59 PM revealed R9 had his left leg amputated recently. CNA N stated he would not let anyone touch it, so they finally convinced him to let them take him to the doctor and that is when it was amputated. CNA N stated there is a wound and dressing on the resident's stump now. CNA N stated she could get R9 up most of the time and sometimes could even get him to come out of his room. A confidential interview (date and time withheld to protect anonymity) revealed they did not feel like there were enough staff to monitor and meet the resident's needs. They reported resident checks, assistance, and cares lacked and/or did not occur as a result of continued staffing problems. They stated they try to perform the duties assigned to them to the best of their abilities but could not always get everything done and noted it impacted the residents. The CNA requested anonymity due to fear of retaliation for any concerns brought to facility administration. A confidential interview (date and time withheld to protect anonymity) revealed there were not enough staff to get things done. The staff member reported the facility had just provided training on the new [EBP] signs placed on resident doors and the PPE located outside of resident doors earlier this shift. The staff member stated they did not report anything to Administrative Staff B due to fear of retaliation. An interview with Licensed Nurse (LN) S on 01/14/26 at 05:04 PM revealed it was typically the director of nursing who updated care plans, but was recently informed it should be the nurses who update care plans if needed. LN S stated R9 still required skin prep to his stump and stated the resident refused a lot. During an interview and review of infection control records on 01/12/26 at 03:44 PM Consultant Nurse C reported she found an Infection Control Binder dated 2024 and one dated 2025, which lacked any tracking of infections, antibiotic review, and/or infectious agent or organism involved if resident's had infections in the building. The infection control binder further lacked any actual infections the residents had and/or monitoring of the effectiveness of the antibiotic. Consultant Nurse C provided a list of residents who received antibiotics and R9 was on the list. Review of the 05/18/24 Wound Treatment Management Policy revealed treatment decisions would be based on the characteristics of the wounds to include presence of pain, presence of infection or need to address bacterial bioburden. The effectiveness of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	treatments would be monitored through ongoing assessment of the wound. Considerations for needed modifications included: lack of progression, changes in characteristics, changes in the resident's goals/preferences. Review of the 06/26/24 Infection Prevention and Control Program revealed the designated infection preventionist was responsible for oversight of the program and serves as a consultant to the staff on infectious diseases, implementing isolation precautions, staff/resident exposures, surveillance and an epidemiological investigation of exposures of infectious diseases.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 34 residents. The sample included 14 residents, with four reviewed for pressure ulcer/injury. Based on observation, interview, and record review the facility failed to ensure effective interventions, accurate assessments, and consistent monitoring, to prevent the development of a facility acquired stage 3 (full thickness pressure injury extending through the skin into the tissue below) pressure ulcer/injury of the sacrum (large triangular bone/area between the two hip bones) for dependent and at risk Resident (R)7, who required hospitalization for wound care and intravenous antibiotics for sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body). The facility further failed to place effective interventions for R6, with a known history of pressure ulcer/injury development. On 12/02/25 a skin assessment revealed the resident had no new skin issues besides an already identified stage 3 pressure injury to his heel. On 12/03/25 the facility identified a Stage 4 pressure ulcer/injury (a deep pressure wound that reaches the muscles, ligaments, or even bone), which had a total wound area measurement of 17.6 centimeters and was an open, full thickness wound covered with dead tissue. Findings included:- The Electronic Health Record (EHR) revealed the resident diagnoses included: stage 2 pressure ulcer of the sacral region, sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body) unspecified organism, peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), pain (unspecified), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and generalized muscle weakness. Review of the 08/11/25 Annual Minimum Data Set (MDS) revealed R7 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS documented the resident had no rejection of care and was dependent on staff for most of her activities of daily living (ADL). The MDS noted R7 was always incontinent of urine and frequently incontinent of bowel. The resident received scheduled pain medication, as needed (PRN) pain medication, and non-medication interventions for pain. The MDS indicated the resident had a pressure ulcer/injury, received a formal assessment instrument/tool, was at risk for pressure ulcer/injury, and had one unhealed pressure ulcer/injury noted as stage 2 pressure ulcer/injury. The 08/11/25 Care Area Assessment regarding Cognitive Loss/Dementia, Functional Abilities (Self-Care and Mobility), Urinary Incontinence, Psychosocial Well-Being, Mood State, and Pressure Injury all lacked development and contained the following work up by the facility in each: wctm - indicating the facility will continue to monitor. The Care Plan, initiated on 10/20/19 and revised on 12/08/24, included R7 had potential for skin impairment and breakdown related to incontinence and impaired mobility, and included the following 5 interventions (with initiated and revision dates):10/20/19, revised on 02/04/25: Weekly skin assessment by licensed staff. Any areas of concern to be reported to the physician/care provider that need outside intervention.03/12/21, revised 02/04/25: Moisture Barrier Ointment to peri area/sacrum for skin protection with incontinence episodes.12/08/24, revised 02/04/25: Staff to complete a Braden quarterly and PRN to identify the resident's risk for skin issues.12/08/24, revised 02/04/25: R7 had a pressure reduction mattress and a cushion in her wheelchair. She required extensive to total assistance from staff to turn/reposition while in bed. She was able to offload while up in her chair.01/28/25, revised 02/04/25: Staff to use two cloth incontinence pads under the resident while she was in bed due to her size and volume of incontinence episodes to avoid moisture related skin breakdown. On 01/13/26, in response to a verbal inquiry on the facility system in place for tracking and monitoring pressure injuries, the facility provided a paper copy of the wound tracking for R7 which included 11 pages of Pressure Ulcer/Injury Evaluations which are included in the following record review. Review of the 04/23/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral open lesion that was chronic (greater than 3 months) and measured 0.6 cm in length (L) by 0.4 cm width (W). The progress section (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	identified the wound as stable: previously deteriorating wound characteristics plateaued and documented it was facility acquired. The assessment did not have a picture of the wound, and the information was completed by Licensed Practical Nurse (LPN), Licensed Nurse (LN) S. The treatment included a generic wound cleanser and a dry adhesive dressing. The evaluation lacked a description of the wound characteristics, wound stage, and lacked mention of the resident pain/condition/tolerance. The 04/23/25 at 11:44 AM N Adv - Skin Check progress note completed by the same Licensed Practical Nurse revealed R7's skin was warm and dry. The note included R7 had two skin issues.Skin issue #1: Skin issue has not been evaluated. Location: Buttocks - generalized. Issue type: Rash. Wound was present on admission. Wound is new.Skin issue #2: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Wound is new. Undermining: No. Tunneling: No. Review of the 04/25/25 at 02:33 AM Monthly Nurses Note Cognitive Patterns revealed R7 was frequently incontinent, R7 currently had skin ulcers, and the ?Nutritional Status' noted The resident's diet is . and did not define the resident's diet. The note did not identify the skin ulcers as pressure ulcers/injuries. The next Pressure Ulcer/Injury Evaluation for R7 was 14 days later on 05/07/25. The 05/07/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral open lesion that was chronic and measured 0.9 cm L by 0.4 cm W, and was facility acquired. The note lacked description of the wound, did not contain an image of the wound, and was completed by LPN, LN S. The treatment included a generic wound cleanser and a dry dressing. The evaluation lacked a description of the wound characteristics, wound stage, and lacked mention of the resident pain/condition/tolerance. The 05/11/25 at 10:47 PM N Adv - Skin Check progress note completed by a Licensed Practical Nurse revealed R7's skin was warm and dry. The included R7 has two skin issues.Skin Issue #1: Skin issue has not been evaluated. Location: Buttocks - generalized. Issue type: Rash. Wound was present on admission. Wound is new.Skin Issue #2: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Wound is new. Undermining: No. Tunneling: No. Review of the 05/13/25 H&P-New Admit Note revealed the resident admitted to Long-Term Care under the services of Physician KK. The note revealed the resident had no known allergies, documented the resident's skin was warm and dry, and noted the resident was in no acute distress. The plan noted the resident had peripheral vascular complication and noted it appeared to be stable at this time. The note listed the resident's medications as:Hydrocodone (narcotic pain medication used to treat moderate to severe pain) 5 mg-acetaminophen 325 mg tablet, one by mouth (PO) every 6 hours (Q6H) as needed (PRN) pain emergency fillHydrocodone 5 mg-acetaminophen 325 mg tablet, one by mouth (PO) every 6 hours (Q6H) as needed (PRN) pain The 05/13/25 H&P-New Admit Note lacked mention of pressure ulcers/injuries for R7. The 05/14/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral open lesion that was chronic and measured 0.7 cm L by 0.4 cm W and was facility acquired. The evaluation was completed by LPN, LN S and did not contain an image of the wound or description. The treatment included a generic wound cleanser and a dry dressing. The next Pressure Ulcer/Injury Evaluation was 14 days later on 05/28/25. The 05/28/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury (partial-thickness skin loss with exposed dermis) that was chronic and measured 0.9 cm L by 0.6 cm W, the wound bed was 10% epithelial (new skin growing in a superficial wound), and was facility acquired. The progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN LN S and did not contain an image of the wound. The treatment included a generic wound cleanser and a dry dressing. The evaluation lacked a description of the wound characteristics and lacked mention of the resident pain/condition/tolerance. The 06/04/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 3 pressure ulcer/injury (full-thickness skin loss with exposed dermis) that was chronic and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	measured 1.0 cm L by 0.6 cm W, was facility acquired, and staged by facility nursing. The progress section documented Monitoring: Wound healed or closed with continued monitoring. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser and a foam primary dressing. The evaluation lacked a description of the wound characteristics and lacked mention of the resident pain/condition/tolerance. The next Pressure Ulcer/Injury Evaluation was 14 days later on 06/18/25. The 06/04/25 Pressure Ulcer/Injury Evaluation staged R7's wound at a stage 3 and the 06/18/25 Pressure Ulcer/Injury Evaluation staged R7's wound as a stage 2. Per the online National Pressure Injury Advisory Panel guidelines on pressure injuries, once a pressure injury was staged it could not have its stage number lowered, noting pressure injuries do not heal backwards through the stages. The 06/18/25 Pressure Ulcer/Injury Evaluation revealed R7 had a chronic sacral stage 2 pressure ulcer/injury that measured 1.1 cm L by 0.5 cm W, and was facility acquired. The progress section documented Monitoring: Wound healed or closed with continued monitoring. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser and a collagen primary dressing. The evaluation lacked a description of the wound characteristics and lacked mention of the resident pain/condition/tolerance. The 06/25/25 Pressure Ulcer/Injury Evaluation revealed R7 had a chronic sacral stage 2 pressure ulcer/injury that measured 0.8 cm L by 0.6 cm W, was facility acquired on 04/02/25, and staged by facility nursing. The wound bed was 70% granulation and 20% slough (did not define the other 10%), and the periwound had rolled edges (epibole) and surrounding tissue had erythema: redness of the skin. The Progress documented Stalled: Previously improving wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser and calcium alginate foam dressing. Per the online National Pressure Injury Advisory Panel (NPIAP) guidelines for pressure injury staging revealed a stage 2 pressure injury would not have granulation or slough tissue. The NPIAP guidelines documented granulation and slough were tissues seen in a stage 3 or stage 4 pressure injury. The 07/02/25 Pressure Ulcer/Injury Evaluation revealed R7 had a chronic sacral stage 2 pressure ulcer/injury that measured 1.1 cm L by 0.7 cm W, was facility acquired on 04/02/25, and staged by facility nursing. The wound bed was 100% granulation and the periwound appeared to have edges flush with the wound bed or as a sloping edge. The Progress section documented Stalled: Previously improving wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser and collagen cleanser and a foam dressing. The 07/09/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.0 cm L by 0.7 cm W, and was facility acquired on 04/02/25. The wound bed was 90% granulation (did not define the other 10%) and the periwound appeared to have edge flush with wound bed or as a sloping edge. The Progress section documented Stalled: Previously improving wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, a collagen primary dressing, and a silicon secondary dressing. The 07/16/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.3 cm L by 0.7 cm W, and was facility acquired on 04/02/25. The wound bed was 90% granulation (did not define the other 10%) and the periwound appeared non-attached where the edge appears as a cliff. The surrounding tissue was documented as fragile: skin that is at risk for breakdown. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included normal saline cleansing solution, collagen primary dressing, and silicone secondary dressing. Review of the Progress Note-Monthly Note electronically signed by Physician KK on 07/23/25 revealed the resident was seen in her room for a monthly regulatory visit. The note revealed the resident continued to do well in the facility, denied any excessive pain, fever, chills, or other issues at the time. The note documented no nursing concerns and included the resident's skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	was warm and dry. The note listed two medications for R7 in the medications section and both were for hydrocodone 5 mg-acetaminophen 325 mg one tablet by mouth every 6 hours for as needed pain and the second entry one tablet by mouth every 6 hours as needed for pain emergency fill. The note lacked mention of a pressure ulcer/injury for R7. The 07/23/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 0.8 cm L by 0.7 cm W, was facility acquired on 04/02/25, and staged by facility nursing. The wound bed was 80% granulation (did not define the other 20%) and the periwound appeared non-attached where the edge appears as a cliff. The surrounding tissue was documented as fragile: skin that is at risk for breakdown. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included normal saline cleansing solution, collagen primary dressing, and foam, silicone secondary dressing. Review of the lab results for R7 collected from her right breast on 07/21/25, revealed the following result: Heavy growth of Staphylococcus aureus The next Pressure Ulcer/Injury Evaluation was 14 days later on 08/06/25. The 08/06/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.6 cm L by 1.2 cm W, and was facility acquired on 04/02/25. The wound bed was 70% granulation (did not define the other 30%) and the periwound appeared to have edge flush with wound bed or as a sloping edge. The Progress section documented Stalled: Previously improving wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser and other primary dressing dated 06/01/25. The 08/13/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 0.7 cm L by 0.8 cm W, and was facility acquired on 04/02/25. The wound bed was 20% epithelial, 80% granulation, and the periwound appeared to have edge flush with wound bed or as a sloping edge. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and silicone secondary dressing. The 08/20/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.4 cm L by 1.4 cm W, and was facility acquired on 04/02/25. The wound bed was 20% epithelial, 80% granulation, and the periwound appeared to have edge flush with wound bed or as a sloping edge. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and silicone secondary dressing. The 08/27/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.5 cm L by 0.9 cm W, and was facility acquired on 04/02/25. The wound bed was 10% epithelial, 90% granulation, and the periwound appeared to have edge flush with wound bed or as a sloping edge. The Progress section documented Stalled: Previously improving wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and foam silicone secondary dressing. The 09/03/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.8 cm L by 1.0 cm W, and was facility acquired on 04/02/25. The wound bed was 10% epithelial, 90% granulation, and the periwound appeared to have edge flush with wound bed or as a sloping edge. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and foam, silicone secondary dressing. The 09/10/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 2.4 cm L by 1.5 cm W, and was facility acquired on 04/02/25. The wound bed was 10% epithelial, 90% granulation, and the periwound appeared to have edge flush with wound bed or as a sloping edge. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and foam, silicone secondary dressing. Review of the Progress Notes in the EHR revealed a 09/12/25 N Adv - Skin Check Late Entry that revealed the resident had no new skin issues identified. The note also include the following three skin issues for R7: Skin Issue: #001: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Additional location information: See skin/wound assessment for details and measurements. Issue type: Pressure ulcer / injury. Undermining: No. Tunneling: No.#002: Skin issue has not been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Wound acquired in-house.#003: Skin issue has not been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Wound acquired in-house.Skin Issues Note: see skin and wound assessment for details. The 09/17/25 Pressure Ulcer/Injury Evaluation revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.6 cm L by 1.1 cm W, and was facility acquired on 04/02/25. The wound bed was 10% epithelial, 70% granulation, 20% slough, and the periwound appeared to have edges flush with wound bed or as a sloping edge. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and silicone secondary dressing. The 09/19/25 at 02:20 PM N Adv - Skin Check, noted as a late entry, revealed the resident's skin was warm and dry, and included the following three skin issues:Skin Issue #1: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Additional location information: See skin/wound assessment for details and measurements. Issue type: Pressure ulcer / injury. Undermining: No. Tunneling: No.Skin Issue #2: Skin issue has not been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Wound acquired in-house.Skin Issue #3: Skin issue has not been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Wound acquired in-house.The documentation revealed the lack of wound description, measurements, staging, and resident condition/pain/tolerance. The next Pressure Ulcer/Injury Evaluation was 28 days later on 10/15/25. The EHR revealed a Discharge Return Anticipated MDS dated [DATE]. The 09/22/25 at 04:15 AM Health Status Note revealed R7 admitted to a hospital for wound care and UTI. The EHR did not contain progress notes to explain what happened to the resident to require the hospitalization. Review of the hospital discharge paperwork dated 09/26/25 revealed a scan of pages 6 of 14, indicating the first 5 pages were missing. The paperwork revealed the resident had a diagnosis of Sepsis with acute renal failure without septic shock. The discharge paperwork included wound care orders as follows:Coccyx wound: Cleanse with normal saline. Protect periwound with barrier spray. Lightly fill wound bed with saline moistened one-fourth inch Iodoform packing strip. Remove excess saline from packing before placing into wound bed. Apply zinc oxide on periwound area, cover with secondary dressing, such as ABD pad or silicone border dressing. Change every other day and PRN for strike through drainage. Date and initial dressing.Bilateral buttocks, sacrum, and perianal area: Gently cleanse area with warm water and wash cloth. Dry thoroughly. Apply generous layer of zinc oxide moisture barrier with each incontinent episode, gently cleanse effluent off leaving clean zinc in place. Re-apply as needed to maintain presence of zinc barrier at all times. The facility 09/26/25 at 03:45 PM N ADV Clinical Admission note included the resident arrived by transportation on a stretcher. R7 had no indicators of pain and the facility did not assess her mouth, other than noting she had he own teeth. The note included the following skin issues for R7: Skin Issue: #001: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Additional location information: See skin/wound assessment for details and measurements. Issue type: Pressure ulcer / injury. Undermining: No. Tunneling: No.#002: Skin issue has not been evaluated. Location: Above right elbow. Issue type: Bruising. Wound was present on admission.#003: Skin issue has not been evaluated. Location: Left front axilla. Issue type: Bruising. Wound was present on admission.Special Care:Source of discharge goal: None of the above.Resident currently on antibiotics. Antibiotic name: Ertapenem [antibiotic used to treat severe bacterial infections] to start 9/27/25 Review of an admission (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Summary Note dated 09/26/25 at 06:38 PM revealed R7 readmitted back to the facility today at 03:45 PM. R7 had an IV present in her left forearm for IV antibiotic. The note included, per the hospital nurse, R7's wound on her coccyx was packed with 1/4 Iodoform (packing strips) and covered with Sacral Heart dressing (sacral foam wound dressing). Review of a Transfer to Hospital Summary dated 09/27/25 at 02:14 PM revealed the resident presented diaphoretic (sweaty), cold, and clammy at 01:45 PM. The staff immediately assessed vitals and R7 had a blood glucose of 147, blood pressure of 124/84, pulse of 98, oxygen saturation level of 96 percent and respirations of 20 per minute. DON notified the physician and orders given to transfer the resident to the local hospital. EMS arrived and picked up R7 at 02:00 PM. Review of a Health Status Note dated 09/29/25 at 06:34 AM revealed resident admitted to the hospital intensive care unit for sepsis, unknown origin, and her WBC was greater than 40,000. Per mayoclinic.org and professional standards of nursing care, in general the normal range for WBC count is between 4,000 and 11,000 cells per microliter of blood and anything greater than 11,000 is considered high and indicative of an infection, with the mayo clinic noting a high white blood cell count is an increase in cells in the blood that fight infections. Review of the 10/03/25 hospital discharge paperwork revealed the resident admitted to the hospital on [DATE] with the chief complaint of malaise and generalized weakness. R7 remained in the hospital from [DATE] until 10/03/25, in the Intensive Care Unit (ICU). The paperwork noted the primary diagnosis was Sepsis and the paperwork contained information on Sepsis, including proper handwashing, and information on infection prevention. The review of systems indicated R7 reported pain in her arms and legs, and pain over the sacral ulcer with no urinary symptoms. The History and Physical (H&P) section of the documentation noted Severe Sepsis present on admission, history of ESBL and MRSA and noted suspect due to UTI (urinary tract infection) however patient was previously growing staph epidermidis (staphylococcus epidermidis is a gram positive bacterium commonly found on skin and known for its potential to cause opportunistic infections, particularly in healthcare settings). The documentation included a picture of the chronic sacrococcygeal ulceration taken on 09/29/25. The paperwork referred to the chronic wound on her coccyx as appears stage 3-4 on clinical evaluation, not obviously infected. Wound care consulted. The continued reasons for hospitalization noted diagnoses of Pressure injury of coccygeal region, stage 2, pressure injury of sacral region, Stage 4, Extended Spectrum Beta-Lactamase (ESBL) Escherichia Coli (E. coli) carrier, and pneumonia of right upper lobe due to infectious organism. Review of the CDC website regarding ESBL-Producing Enterobacterales revealed ESBL are resistant to common antibiotics and may require complex treatments, can occur both in and outside of healthcare settings, and good hand hygiene and infection prevention practices can help reduce infection risk. ESBLs break down certain antibiotics, making some infections caused by ESBL-producing Enterobacterales difficult to treat. ESBL-E infections are resistant to many prescribed antibiotics, such as penicillin and cephalosporins. The infections caused by ESBL might require hospitalization and IV antibiotics. ESBL-E can cause several different infections, including urinary tract and bloodstream infections. These bacteria can also live in a patient without causing infection or symptoms, known as colonization. ESBL can spread from person to person through dirty hands and surfaces. The website identified nursing home settings as those at risk. Review of the 10/03/25 at 07:17 PM facility N ADV Clinical Admission documentation revealed R7 readmitted to the facility. The note included R7 reported no pain and she had the following skin issues:Skin Issue #1: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Additional location information: See skin/wound assessment for details and measurements. Issue type: Pressure ulcer / injury. Undermining: No. Tunneling: No.Skin Issue #2: Skin issue has not been evaluated. Location: Above right elbow. Issue type: Bruising. Wound was present on admission.Skin Issue #3: Skin issue has not been evaluated. Location: Left front axilla. Issue type: Bruising. Wound was present on admission.The note lacked further information such as wound information, measurements, or staging. Review of the EHR revealed a verbal order dated 10/04/26 at 04:25 PM indicating to send R7 o the emergency room for diaphoretic episode. STAT (immediately). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility Transfer to Hospital Summary note dated 10/04/25 at 07:58 PM revealed the resident presented cold, clammy, and diaphoretic. The resident was not responding to questions to determine alert and oriented status. Vitals included: blood pressure (BP) 104/54 millimeters of mercury (mmHg), pulse (P) of 99 beats per minute (bpm), respirations 16 breaths per minute, temperature of 97.2 degrees Fahrenheit (F). The following vitals were outside of normal limits:Oxygen (O2) saturation percentage (%) of 75% (normal range 95 - 100%)Blood glucose (BG) was 93 milligrams per deciliter (mg/dL) (normal for diabetic at bedtime is above 180 mg/dL) . The staff notified the DON and put the resident on 2 liters of oxygen, which resulted in the resident oxygen saturation of 83%. EMS contacted to request pick up and patient transport to local hospital. Upon EMS arrival resident's blood pressure lowered to 74/41 mmHg, and R7 left the facility with EMS at 04:40 PM. A Pressure Ulcer/Injury Evaluation dated 10/15/25 revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 1.7 cm L by 1.1 cm W, and was facility acquired on 04/02/25. The wound bed was 80% granulation (did not define the other 20%) and the periwound appeared to have non-attached edges, which appear as a cliff. The surrounding tissue was excoriated: superficial loss of tissue. The progress section documented Stalled: previously improving wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and silicone secondary dressing. A Pressure Ulcer/Injury Evaluation dated 10/22/25 revealed R7 had a sacral stage 2 pressure ulcer/injury that measured 2.0 cm L by 1.2 cm W, and was facility acquired on 04/02/25. The wound bed was 80% granulation, 20% slough, and the periwound appeared to have non-attached edges, which appear as a cliff. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and silicone secondary dressing. A Pressure Ulcer/Injury Evaluation dated 10/28/25 revealed R7 had a sacral stage that measured 1.7 cm L by 1.2 cm W, and was facility acquired on 04/02/25. The Progress section documented Improving: overall wound characteristics improved. The evaluation was completed by LPN, LN S and did not contain an image of the wound or treatment information. A Pressure Ulcer/Injury Evaluation dated 11/04/25 revealed R7 had a sacral stage 3 pressure ulcer/injury that measured 1.6 cm L by 1.2 cm W, and was facility acquired on 04/02/25. The wound bed was 10% epithelial, 70% granulation, 20% slough, and the periwound appeared to have non-attached edges, which appear as a cliff. The surrounding skin was fragile: skin that was at risk for breakdown, normal in color. The Progress section documented Stable: previously deteriorating wound characteristics plateaued. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and silicone secondary dressing. A Pressure Ulcer/Injury Evaluation dated 11/11/25 revealed R7 had a sacral stage 3 pressure ulcer/injury that measured 1.6 cm L by 1.0 cm W, and was facility acquired on 04/02/25. The wound bed was 10% epithelial, 90% granulation, and the periwound appeared to have attached edges, which appear flush with wound bed or as a sloping edge. The surrounding skin was normal in color. The Progress section documented Improving: overall wound characteristics improved. The evaluation was completed by LPN, LN S and did not contain an image of the wound. The treatment included generic wound cleanser, collagen primary dressing, and foam secondary dressing. A Pressure Ulcer/Injury Evaluation dated 11/18/25 revealed R7 had a sacral stage 3 pressure ulcer/injury that measured 1.8 cm L by 1.1 cm W, and was facility acquired on 04/02/25. The wound bed was 20% slough, 90% granulation, and the periwound appeared to have attached

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 34 with 14 in the sample. Based on observation, interview, and record review the facility failed to address Resident (R) 16's complaints of pain in her hip. On 07/19/25 the resident voiced pain in the hip after a self-reported fall. After lidocaine (pain medication) patches and Tylenol (pain) were not effective managing the resident's pain the facility placed an order for hydrocodone-acetaminophen (narcotic pain medication) 5-325 milligrams (mg) on the resident's record on 08/12/25, however failed to obtain the medication until 08/25/25. The resident reported pain almost daily at a 1 to 8 on a pain scale where 0 is no pain and 10 is the worst pain imaginable from 08/12/25 until 08/21/25. The facility further failed to ensure R7, received needed dental care and services. R7 refused her dental visit on 10/30/25. The record lacked evidence of staff attempts to get R7 to a dentist after her 10/30/25 refusal, and approximately two months R7 began complaining of tooth pain. The records revealed R7 had an infection to her left lower molar, which caused her pain, affected her eating, and required antibiotics to treat. Findings included:- Resident (R) 16 admitted to the facility on [DATE] and left to and returned from the hospital on [DATE]. Review of R16's Electronic Health Record (EHR) revealed the resident had a diagnosis of pain in the left hip. The resident's admission Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 11, which indicated moderately impaired cognition. The resident received as needed pain medications during the last 5-day observation period and received no non-medication interventions for pain. Review of the 07/09/25 Care Area Assessments (CAA) revealed the pain CAA did not trigger for further review. The Functional Abilities (Self-Care Mobility) CAA triggered but lacked any further development or documentation. Review of the 09/25/25 Quarterly MDS assessment revealed the resident had a BIMS score of 14, which indicated intact cognition. The resident required as needed pain medications during the last 5-day observation period and received no non-medication interventions for pain. The resident's Care Plan initiated 07/03/25 lacked any interventions related to the resident's pain or falls. R16 reported a fall on 07/19/25 and the resident's care plan lacked any intervention related to the fall and/or her subsequent left hip pain. On 08/11/25 staff were instructed to administer medications as ordered and monitor/document for side effects and effectiveness The 07/19/25 at 02:36 PM Health Status Note revealed the resident complained of left hip pain. She limped and was unable to put full weight on the left foot. The note identified the resident as a poor historian and noted the writer was unable to confirm, but R16 reported she fell on her hip before arriving at the facility [on 07/03/25, 16 days prior]. The note stated the resident could fully bare weight upon admission, but her symptoms were steadily worsening. The resident's physician ordered a stat x-ray. The mobile radiology could not perform an x-ray until Monday, so the facility obtained orders to send to the local hospital for evaluation and treatment. The 07/19/25 After Visit Summary document revealed the resident was evaluated for pain in the left hip and declined an x-ray at the time of the visit. The 07/19/25 at 08:25 PM Communication with Hospital Note revealed the resident returned to the facility from the hospital after refusing an x-ray. R16 requested can't you have them [mobile radiology] come here to do it, I don't have any money and don't want to lose this bed, home. The writer stated they would ask the resident's provider for an order to have the x-ray completed at the facility and educated the resident that the hospital placed a Lidocaine patch on her hip with no additional new orders, so she could not have anything stronger than Tylenol for pain. On 07/20/25 at 10:12 AM a Health Status Note revealed the nurse contacted mobile radiology to set up the x-ray as ordered by the resident's physician on 07/14/25. They reported they had staff scheduled to arrive at the facility mid-morning, on Monday. The mobile radiology company stated that since the resident had Medicaid insurance pending the consent to pay form needed to be signed by either patient or facility, so the writer notified the Director of Nursing (DON). The progress notes lacked documentation this request was followed up on by the DON. Review (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	of the Patient Report Form dated 08/13/25 revealed the resident had an x-ray of the left hip and pelvis, which revealed no acute fracture or lesion and no dislocation. Review of the August 2025 MAR/TAR revealed the resident had an order for hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg), one tablet by mouth every six hours as needed for pain in the left hip, which started on 08/12/25 and discontinued on 08/21/25. The record lacked evidence the facility ever provided the medication to R16. The MAR revealed blank slots for the days, with no staff documenting they provided the medication to the resident. Review of the August 2025 MAR/TAR assessment of R16's pain from 08/12/25 to 08/21/26 revealed the resident had pain almost daily and it ranged from a 1 - 8 on the pain scale. The 08/21/25 at 08:25 PM Order Note revealed an order for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), staff were to give 1 tablet by mouth every 6 hours as needed for pain in the left hip. The resident was on tramadol (pain medication) for moderate to severe pain in left hip. The resident stated that tramadol was not working and showed verbal and nonverbal signs of pain. Review of the resident's Orders tab in the EHR revealed the resident received a physician's order on 08/21/25 for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg. Staff were to give one tablet by mouth every six hours as needed for pain in the left hip. Review of the Progress Note-Monthly Note dated 08/23/25 revealed the resident had ongoing hip pain, was awaiting x-ray results on the hip and the resident utilized Norco and lidocaine patches for pain management. Review of the August 2025 MAR/TAR revealed the resident received a lidocaine external patch applied topically one time a day for pain, the entire month. The resident received 650 mg two times a day for pain, the entire month. Review of the MAR/TAR revealed the resident did not receive a Norco until 08/26/25, even though the resident had documented physician orders for the medication since 08/12/25. Review of the Pharmacy Narcotic Delivery Log for August 2025 revealed the pharmacy did not deliver hydrocodone-acetaminophen 5-325 mg until 08/25/25. Review of the signed Physician Order dated 08/26/25 revealed a hand signed order for Norco (hydrocodone-acetaminophen) 5-325 mg, one tablet every four hours as needed. The resident's MAR/TAR never reflected the physician's order indicating the resident could take the medication as needed every four hours instead of every six hours. An observation of R16 on 01/11/26 at 07:03 PM revealed a staff member assisted the resident to stand up out of a chair by lifting her arm, without the use of a gait belt. The resident struggled to stand up, and the staff member pulled at her arm until she arose from the chair. An interview with Certified Nurse's Aide (CNA) N at 01/14/26 at 03:59 PM revealed the facility did not utilize a report sheet or documentation, they just gave report via shift-to-shift rounds where they told each other if anything changed, or if residents were sick or weaker than normal. R16 could get up by herself sometimes unassisted, but at times she really needed help getting up. If a resident complained of pain, she would report it to the nurse and would follow up if the resident continued to complain of pain. CNA N stated R16 dealt with a lot of pain. R16 had a chair that reclined and now that she does not have it, she is getting worse. R16's hip is the source of her pain. An interview with Licensed Nurse (LN) S at 05:04 PM on 01/14/26 revealed the chairs in the commons area of the facility sit so low that the resident has to have someone help her stand up. She stated the resident complained about generalized pain and sometimes would tell the staff different things. An interview with Consultant Nurse C 01/14/26 5:45 PM revealed if a resident complained of pain, staff were expected to assess and treat the pain. If the resident did not have an as needed order for the pain medication they were to get and order, follow up with effectiveness and/or try nonpharmacological things like repositioning. Review of the 06/26/24 Pain Management policy revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. - R7's Electronic Health Record (EHR) revealed the resident diagnoses included pain and sepsis. Review of the 08/11/25 Annual Minimum Data Set (MDS) revealed R7 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS documented the resident had no rejection of care (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	and was dependent on staff for most of her activities of daily living (ADL). The resident received scheduled pain medication, as needed (PRN) pain medication, and non-medication interventions for pain. The 08/11/25 Care Area Assessment regarding Cognitive Loss/Dementia, Functional Abilities (Self-Care and Mobility), Psychosocial Well-Being, and Mood State all lacked development and contained the following work up by the facility in each: wctm - indicating the facility will continue to monitor. The Care Plan for R7 revealed an intervention initiated 11/19/18, revised 02/04/25, and included R7 had her own teeth and staff were to set up supplies for her to brush her teeth, twice a day. Review of the 05/13/25 H&P-New Admit Note revealed the resident admitted to Long-Term Care under the services of Physician KK. The note listed R7's medications as:Hydrocodone (narcotic pain medication used to treat moderate to severe pain) 5 mg-acetaminophen 325 mg tablet, one by mouth (PO) every 6 hours (Q6H) as needed (PRN) pain emergency fill.Hydrocodone 5 mg-acetaminophen 325 mg tablet, one by mouth (PO) every 6 hours (Q6H) as needed (PRN) pain. Review of the Progress Note-Monthly Note electronically signed by Physician KK on 07/23/25 revealed the resident was seen in her room for a monthly regulatory visit. The note revealed the resident continued to do well in the facility, denied any excessive pain, fever, chills, or other issues at the time. The note listed two medications for R7 in the medications section, and both were for hydrocodone 5 mg-acetaminophen 325 mg one tablet by mouth every 6 hours for as needed pain and the second entry one tablet by mouth every 6 hours as needed for pain emergency fill. Review of the 10/15/25 at 09:25 AM N Adv - AIMS Evaluation revealed the resident does not currently have problems with teeth. Review of the 10/30/25 at 12:43 PM Social Services Progress Notes revealed R7 refused to see 360 dental today. The EHR revealed no further Progress Notes regarding 360 dental or dental appointments for R7. Review of the 12/30/25 at 10:40 AM Order Note revealed the Penicillin V Potassium Oral Tablet 500 MG, give 500 mg by mouth two times a day, for dental infection for 5 days. Review of the 12/30/25 at 10:42 AM No Type Specified note revealed R7 complained of dental pain and had redness and some swelling to her left lower molar tooth. The note documented an order was written. Review of the 01/08/26 at 01:53 PM N Adv Skilled Evaluation revealed R7 had complaints of pain and discomfort to her lower left jaw, noted singular tooth in place with inflamed gums surrounding tooth, and oral care provided by the writer that day. The evaluation noted the resident had mouth or facial pain, discomfort or difficulty with chewing. Observation on 01/14/26 at 01:32 PM revealed R7 laid in bed in her room and picked her teeth with her fingernails. R7 stated her bottom left tooth in the back was hurting her, and it hurt to eat for the last two weeks. R7 stated she grinds her teeth and would like to see the dentist, as they gave her numbing gel, but it did not really help. During an interview with Certified Nurse Aide (CNA) N on 01/14/26 at 03:59 PM revealed if a resident complained of dental pain, they would tell the Social Services Designee and noted the facility had a dentist that visited every 3 months but would come out for emergency visits. CNA N stated about 2 weeks ago R7 was having a hard time eating and holding her mouth and said her tooth hurts, on a single tooth, gums swollen and red. The nurse checked it out and SSD said they would contact the dental group, but CNA N did not know if they came out or not, but knew the tooth was still there and hurting R7 really bad. CNA N said she talked to hospice and the SSD about R7 still hurting. CNA N stated if a resident complained of pain in general, she informed the nurse and if Tylenol (acetaminophen) was needed the staff told the medication aide or use BioFreeze or lidocaine patch and let the nurse know if the resident still complained of pain. CNA N stated R7 had a wound on her coccyx that hurts her quite a bit and even before that, she has always been in quite a bit of pain. She stated R7 broken her leg years ago and always had pain in that leg. CNA N said now that hospice has come in and was helping with R7's pain management, she felt like it was helping R7 more and she was doing better, but her tooth was bothering her a lot. During an interview on 01/14/26 at 05:04 PM, Licensed Nurse (LN) S said if a resident complained of dental pain the staff reported it to the doctor, looked at it, and checked if they can get the resident to see a dentist. LN S said they were going to try and get R7 into a dentist, noted R7 had complained about generalized pain, sometimes would tell staff different things. LN S stated if (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	a resident complained of pain, she assessed them for what kind of pain, see if chronic or new to them, if new would assess further for any injury. LN S said if the resident had a PRN medication ordered she would offer it. LN S said R7 complains of pain everywhere or sometimes it was her back. LN S said R7 had a PRN pain medication, but yesterday it was changed to scheduled. During an interview with Consultant Nurse C on 01/14/25 at 05:45 PM revealed she expected the charge nurses to update the care plan. Consultant Nurse C stated special needs should be care planned. She stated the care plan should list behaviors, triggers, and interventions for individual residents, and staff should know through care plans how to get into the care plan to provide the best care. Consultant Nurse C stated the care plans should be as individualized as possible to provide the best care, including ADLs. Consultant Nurse C stated if a resident complains of pain, staff should assess and treat, hopefully have a PRN order or get an order, and follow up if it was effective. She stated sometimes it did not require medication, and the resident might need repositioning and try different things. Review of the facility provided Dental Services Policy, dated 11/06/23, revised 06/24/24, revealed emergency dental services included services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. The policy noted all actions and information regarding dental services, including any delays related to obtaining dental services, would be documented in the resident's medical record. The policy noted the SSD maintained contact information for providers of dental services that were available to facility resident at a nominal cost.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. The facility identified a census of 34 residents. Based on record review and interviews, the facility failed to establish and implement an admissions agreement that protected the residents' right to personal property. Findings included:- The facility's Skilled Nursing Facility Resident Agreement revealed under part four, page 14, section D Personal Possessions that the resident, under no circumstances, held the facility responsible for or liable of any nature whatsoever for the loss or damage to valuables, personal property, or money brought into the facility. On 01/14/26 at 06:25 PM, Administrative Staff D stated the regional level completed the admission agreement packets and sent them out. She stated when a resident admitted to the facility staff completed an inventory list with the resident and updated it with anything new brought in. Administrative Staff D stated if a resident stated they brought items in and they followed the grievance process; the facility did an investigation to find the item then took ownership after the facility verified the item went missing in the facility. She stated the admission agreement statement did not protect residents from misappropriation. The facility's admission Policy- Kansas, last revised 09/26/25, directed an admission agreement shall not include a general waiver of liability for the health and safety or residents.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. The facility identified a census of 34 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to provide a resident centered activities program that incorporated resident interests, hobbies, and cultural preferences for a meaningful life. Findings included:- The activity calendar for January 2026, documented the following activities from 01/01/26 to 01/14/26: 01/01/26 - 02:00 PM Bingo, 07:00 PM free hour. 01/02/26 - 10:00 AM exercise group, 02:00 PM movie and popcorn, 07:00 PM free hour. 01/03/26 - 10:00 AM exercise group, 02:00 PM coloring creations, 07:00 PM free hour. 01/04/26 - Exercise group, table games, and free hour. The scheduled times were cut off of the calendar. 01/05/26 - 10:00 AM Christmas undecorating, 10:30 AM Resident Council, 02:00 PM mani time, 07:00 PM free hour. 01/06/26- 10:00 AM exercise group, 10:00 AM word search, 02:00 PM Bingo, 07:00 PM free hour 01/07/26- 10:00 AM exercise group, 10:30 AM cooking with Activities Director E, 02:00 PM corn hole, 07:00 PM free hour 01/08/26- 10:00 AM exercise group, 10:00 AM ladies club, 02:00 PM Bingo, 07:00 PM free hour 01/09/26- 10:00 AM exercise group, 10:30 AM men's club, 02:00 PM movie and popcorn, 07:00 PM free hour 01/10/26- 10:00 AM exercise group, 02:00 PM coloring creations, 07:00 PM free hour 01/11/26- exercise group, table games, and free hour. The scheduled times were cut off of the calendar. 01/12/26- 10:00 AM exercise group, 10:30 AM coffee social, 10:30 AM trivia, 02:00 PM mani time, 07:00 PM free hour. 01/13/26- 10:00 AM exercise group, 10:30 AM balloon toss, 02:00 PM Bingo, 07:00 PM free hour. 01/14/26- 10:00 AM exercise group, 10:30 AM cooking with Activities Director E, 02:00 PM happy hour, 07:00 PM free hour. On 01/13/26 at 02:07 PM, Resident (R) 23, R17, R20, R16, R31, R3, R29, R14, and R34 sat at tables in the dining room and waited to play scheduled Bingo. On 01/14/26 at 10:16 AM, R34 and R14 sat at tables in the dining room and participated in coloring. There were other residents in the dining room that watched television. R1 sat in her wheelchair in the day area with a coloring page and colored pencils/markers in an unopened box in front of her. R1 did not participate in coloring. On 01/14/26 at 10:30 AM, the scheduled activity of cooking with Activities Director E did not occur. On 01/14/26 at 02:04 PM, R20 sat in the dining room and colored pages. Happy hour was scheduled at 02:00 PM and R17, R16, and R29 sat in the day area. Music played in the area. On 01/14/26 at 02:07 PM, Activities Director E asked R29 in the day area if she wanted to go into the dining room for activities. On 01/14/26 at 02:10 PM, Activities Director E propelled R23 into the dining room for activities. 01/11/26 at 07:15 PM R18 stated activities did not meet his interests due to his age, the other resident's ages, and their preferences. He stated he enjoyed watching a movie recently, but that was about all they did that he liked. On 01/14/26 at 12:54 PM, R23 stated the facility did not have exercise group or cooking that morning as scheduled. On 01/14/26 at 03:44 PM, Activities Director E stated she followed an activity book to get ideas of activities to do. She stated she interviewed residents on what activities they liked to do. She stated she used to do more activities for the elderly but there had been a change in the population and needed to learn new activities those residents would like. Activities Director E stated she tried to follow the activity calendar but somedays nobody wanted to get up for exercise group or do a scheduled craft, so she had to switch to a game. She stated she tried to do a different activity if the residents did not want to do the scheduled one. Activities Director E stated she did not do cooking this morning because she did not have the chocolate chips. She stated they did not do exercise group this morning because nobody wanted to do it, so she did coloring pages instead. Activities Director E stated each resident had an activity care plan and the assessment identified preferences that she put on the care plan. On 01/14/26 at 05:45 PM, Consultant Nurse C stated activities should be resident specific for age and demographic. She stated she expected staff to assess the resident demographic and make activities enjoyable and meaningful. Consultant Nurse C stated she expected the activity calendar to be followed and if staff had to deviate from it, staff communicated the change to the residents and found something as equally engaging and enjoyable. The facility's Activities policy, dated 07/19/23, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	directed the facility provided all residents with an ongoing program of activities designed to meet, in accordance with their comprehensive assessment, their interests and their physical, mental, and psychosocial well-being.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. The facility census totaled 34 with 14 in the sample. Based on interview and record review the facility failed to ensure staff had the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident as determined by resident assessments, plans of care and utilizing the facility assessment. Findings included:- The facility failed to provide evidence of competencies from Administrative Staff A as requested on 01/11/26 and again on 01/12/26. During an interview on 01/26/25 with Consultant Staff X at 03:51 PM she stated she did not have any proof the facility performed competency evaluations with certified staff. Review of the Sufficient Staff Policy dated 05/15/24 revealed the facility would provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility reported a census of 34 residents. Based on interview and record review the facility failed to provide evidence of no less than twelve hours of in-service education provided to the Certified Nurse Aides annually, which were based on their individual performance reviews. This failure had the ability to affect the care of all 34 residents. Findings included:- The facility failed to provide evidence of competencies and evidence of annual in-service education for the Certified Nurse Aides, as requested from Administrative Staff A on 01/11/26 and again on 01/12/26. During an interview with Administrative Staff A on 01/13/26 at 03:10 PM she stated that they were still looking and could not locate the information, noting they looked through Administrative Nurse B's office but were not able to locate any documentation about annual CNA training based on performance reviews. During an interview on 01/26/25 with Consultant Staff X at 03:51 PM she stated she did not have any proof the facility performed competency evaluations with certified staff. Review of the Sufficient Staff Policy dated 05/15/24 revealed the facility would provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. The facility reported a census of 34 residents. Based on observation, interview, and record review revealed the facility failed to ensure effective administration in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This failure affected all 34 residents in the facility. Findings included:- During an extended recertification and complaint survey the following concerns were identified regarding the lack of administrative oversight, which contributed to the following three immediate jeopardy deficiencies as follows: Regarding Accident Hazards (See F689): Based on observation, interview, and record review the facility failed to prevent, identify, and intervene in Resident (R) 11's substance use disorder, which placed residents in immediate danger of serious harm or death R11 admitted to the facility after a referral from a regional hospital. The 08/13/25 hospital referral sheet for admission to the facility identified the resident with a history of alcohol and drug use with the resident reporting current drug use at the time of the referral. Administrative Staff A and Administrative Nurse B failed to ensure R11 had trained/competent staff with the skills to care for a resident with SUD, support resources (consultant psychiatric provider was not referred until 09/2025 weeks after admission and only saw the resident monthly), and/or care planned interventions to address his substance use disorder (SUD). On 08/29/25 the resident developed blisters to fingers on both hands, but the resident's record lacked follow up by Administrative Staff A and/or Administrative Nurse B to the injuries of unknown origin (the resident's record does not indicate the resident stated how he obtained the wounds) and/or investigation into the causal factors of the blisters. R11 was identified cutting scabs off of himself with a knife and with non-facility managed medication and Administrative Staff A and Administrative Nurse B failed to investigate or follow up on the identified concern, when the resident had undocumented medication and a known history of SUD and self-harming behaviors to address R11's SUD and his highest practicable well-being. On 12/26/25 staff found four pill bottles, a torch, a red lighter, a large knife, and a black pouch containing a drug pipe in R11's room. Administrative Staff A was notified and failed to follow up on the incident. During an interview on 01/13/26 at approximately 07:00 PM Administrative Staff A verified she was aware of the items staff found in R11's room and did not know what staff did with the drug pipe, pill bottles, lighter/torch, and knife. Administrative Staff A denied having knowledge of what was in the pill bottles. Administrative Staff A originally stated law enforcement picked up the drug pipe, but then said they did not and were not notified. Administrative Staff A stated she was unaware that a resident with known SUD having a drug pipe in his possession would require further investigation. On 01/10/26 dayshift staff reported to the nightshift nurse that R11 appeared to be intoxicated with pinpoint eyes and a very red face. Administrative Staff A gave permission for staff to search the residents room, although he declined. Upon a search of the resident's room staff found a crack pipe with the contents the facility identified as methamphetamine still present. During the events on 01/10/26 the methamphetamine spilled out of the pipe and onto the medication cart that housed the other residents who resided in the facility's medication. Facility administration failed to provide oversite in handling an illegal drug, until law enforcement could retrieve the substance. Facility administration failed to ensure staff had a system for monitoring R11 for overdose, withdrawal, and continued substance abuse. Facility administration failed to ensure all staff were aware R11 had drug paraphernalia on 12/26/25 and staff stated they wished they knew so they could have monitored the resident before he had an incidence of smoking methamphetamine in the facility, with other residents potentially present in the vicinity within hallways and their rooms. Administrative Staff A failed to initiate an investigation into R11 having drug paraphernalia, illegal drugs, knives, and lighters/torches in his possession and while intoxicated on an unpredictable illegal substance, which had the potential to impact all residents in the facility. On 01/13/26 at approximately 07:00 PM Administrative Staff A stated she was not aware if a resident smoking methamphetamine in the facility was reportable or required an investigation. During (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	confidential interviews with staff, they reported they were fearful to report anything to administration out of fear of retaliation. Regarding Pharmacy Services (See F755):The facility reported a census of 34 residents. Based on observation, interview, and record review the facility lacked a system for records of receipt through disposition of all controlled medications, in sufficient detail to enable accurate reconciliation and ensure drug records were in order. The facility also failed to ensure a record system to account for all controlled medication which was maintained and periodically reconciled. The facility pharmacy lacked onsite presence in the facility to assist in the destruction of controlled narcotic substances from February 2025 until 01/09/26. The facility had a locked cabinet inside the medication room used for narcotic medications awaiting destruction. The administrator did not know who had the key for the locked cabinet and required maintenance staff to cut the lock off of the cabinet on 01/06/26, revealing the cabinet was full of narcotic controlled medications dating back to 2024. Through record review the facility could not account for 49 separate narcotic prescriptions, of an unknown quantity each, affecting 22 current and discharged residents. The pharmacy did not identify the increased use of e-kit narcotics used, increased frequent changes to narcotic prescriptions, and lack of destruction of the numerous narcotic medications delivered, or the lack of a facility system in place for the accurate accounting of controlled substances to include PRN and discontinued narcotic medication. On 01/12/26 review of resident chart revealed the facility did not have her hydrocodone and had to access the e-kit twice to provide pain medication for the residents. The lack of pharmacy services, procedures, and records placed all residents who received controlled narcotic medications in immediate jeopardy and at risk for unrelieved pain, discomfort, death, and the risk to the resident population which included a history of Substance Use Disorder. During the investigation, the surveyor asked for the count sheet for R36's oxycodone (narcotic pain medication) or evidence the resident took the medication home, since these were identifiable in the complaint photos. The facility could not provide a copy of the count sheet for the medication, and it was requested twice of Administrative Staff A, twice of Administrative Nurse B, and once of Licensed Nurse S. During an interview on 01/06/26 at 01:57 PM Administrative Staff A stated the facility did not have the count sheets for R36's oxycodone and did not have evidence that R36 took it home. Administrative Staff A stated she could not find it and it did not look like the facility had it. During an interview on 01/06/26 PM at 12:06 PM, Administrative Staff A stated she has never been in the facility when the narcotic medications were destroyed, stated she was not a nurse, and she does not have anything to do with medications. Administrative Staff A stated she never saw pharmacy in the facility to destroy narcotic medications and said Administrative Nurse B should have the narcotic destruction key. Administrative Staff A stated she had not asked Administrative Nurse B if she had key, but she should have it and thought she did. She further stated per the facility policy, narcotic medication destruction required a licensed nurse or nurse and certified medication aide or pharmacist. Administrative Staff A stated it could be an issue with Administrative Nurse B having a key and all count sheets going to her, as a single point. Administrative Staff A stated as far as she knew Administrative Nurse B had the key and she did not know who else would have it. Administrative Staff A stated as far as she knew the pharmacy had not been out, but said they may not check in with her when they do since she does not do anything with medications, but had never seen them. Administrative Staff A stated the pharmacist sent out pharmacy recommendations once a month, so she was in contact with them and stated there absolutely should be a record of what was destroyed, but was not positive if or where the record could be. She stated there should be a book of record of what was destroyed and she was not sure if it was at the nurses station or in her office, but there should be a record of it. Administrative Staff A stated she could see how it could be an issue with only Administrative Nurse B as the staff member with the key to the narcotic destruction cabinet and all counts sheet going to Administrative Nurse B. During an interview on 01/06/26 at 02:27 PM Administrative Staff A she was not sure about the key and no one she talked to knew where it was or knew who had it. During an interview on 01/06/26 at 03:27 PM Administrative Staff A stated they (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	asking them about and stated a CMA thought it was the lockbox on the medication cart. Administration Staff A stated that everyone that is here is safe and no medications were missing from them. Administrative Staff A said the facility provided a list of medications they prescribed sent from the pharmacy they audited it with the list that were here and what was delivered. Administrative Staff A stated they know that there are medications the pharmacy said they sent, that are no longer in the facility, that we did not know were missing because they should have been in the box, but they were not. Administrative Staff A stated that some of the stuff [medications] in the destruction cabinet was very old and one of them was dated 2024. She stated she knew that the pharmacy had not destroyed medications. She stated inside the destruction cabinet was a metal box and she said it had empty bottles repeating they were all empty. When asked if she inventoried the items inside the metal box, she stated she did not inventory anything in there. Kinda looked in it and they were all empty. Administrative Staff A stated she saw the medications inside the cabinet and knew someone was accessing it as there was no way to toss in something form the top slot and get it into the metal box at the bottom. Administrative Staff A stated once she was notified of this incident she immediately suspended Administrative Nurse B, pending investigation, and then started her investigation. Administrative Staff A stated she was notified on 01/06/26 of the allegation. She said on 01/07/26 she asked Administrative Nurse B to complete a drug test by 04:00 PM on 01/07/26 but Administrative Nurse B did not complete a drug test because she missed the time. Administrative Staff A said she knew the time was running out on this and told Administrative Nurse B to complete a drug test by 09:00 AM on 01/08/26, but when Administrative Staff A called Administrative Nurse B at 10:00 AM on 01/07/26, she woke Administrative Nurse B up. She said Administrative Nurse B did not complete a drug test until after 02:00 PM on 01/08/26. Administrative Staff A stated a week before this other staff came to her with concerns regarding Administrative Nurse B and her performance and what she was and was not doing. Administrative Staff A stated she knew of things Administrative Nurse B was not taking care of and thought she just needed more training. Regarding Infection Control (See F880):Based on observations, interviews and record review facility administration failed to administer an effective infection prevention and control program. Observation of the facility on 01/11/26 revealed multiple resident rooms with clothing strung all over floor and the bed side tables of residents, with a strong smell of urine throughout the facility. The facility lacked a system to store soiled resident clothing in a manner to prevent the spread of potentially infectious organisms. Administrative Staff A walked throughout the facility, likely observing the clothing and failed to address the lack of infection control practices. Administrative Staff A further failed to ensure staff had the knowledge and cleaning supplies necessary to clean/disinfect multi resident use medical equipment after each use. Administrative Staff A further failed to ensure a complete and effective infection prevention and control program by the failure to track infections in the building, identify organisms present, implement enhanced barrier precautions for residents at risk for multi-drug-resistant organism due to wounds, catheter use, or other medical device use. On 01/11/26 Administrative Staff A reported not being a nurse so was unaware of Administrative Staff Bs role and responsibility if it had any nursing implications. Consultant Nurse C further failed to implement immediate corrective actions regarding infection control practices when on 01/12/26 she identified Administrative Staff B lacked documentation for tracking and trending of infections in the building, failed to identify organisms present while administering antibiotic medication to residents, and failure to provide oversight to ensure staff were aware of and adhering to infection control practices. Administrative Staff A failed to ensure the most recent facility assessment thoroughly addressed Infection Prevention. Administrative Staff A failed to maintain documentation that Administrative Nurse B had the education, experience, or certification to be designated as the facility Infection Preventionist. Administrative Staff A failed to provide oversight to ensure the facility maintained a water management program for the prevention and spread of waterborne infectious organisms, even though it was cited on the facility's most recent annual survey dated 04/2025. During confidential (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interviews with staff they reported they were fearful to report anything to administration out of fear of retaliation.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The census totaled 34 with 14 in the sample. Based on interview, and record review the facility failed to conduct an effective facility-wide assessment to determine the resources necessary to care for its residents competently during day-to-day operations. Findings included:- Review of the facility provided Facility Assessment Tool revised 11/2025 revealed the facility had 45 licensed beds with the average number of occupied beds being 32 the last quarter. Review of the Persons Involved in completing the assessment revealed the administrator, director of nursing, social services director, medical director and physical therapy. The document lacked evidence the facility included input from other members of the community as required in section 483.71(b)(1)(ii)(iii) of the State Operations Manual, which include (but not limited to) direct care staff (registered nurse, licensed practical nurse, nursing assistants), residents, resident representatives, and family members. The assessment further lacked a plan to maximize recruitment and retention of direct care staff. The Acuity section instructed the facility to describe resident's acuity levels that would help the facility understand potential implications regarding the intensity of care and services needed. Review of the Major RUG-IV Categories lacked a number/range of residents who required extensive services, special care high services, special care low services, clinically complex cares, behavioral symptoms and cognitive performance, and/or residents with reduced physical function. The facility provided Facility Assessment Tool instructed the facility to describe the staff training/education and competencies that were necessary to provide the level and types of support and care needed for the resident population. The facility noted they would do annual competencies (with no description), monthly in-services with education (without description or further development), and/or provide education as needed. The assessment further instructed staff to describe the staff education and competencies, staff certification requirements, testing policies, competency and how to evaluate the efficacy of these to ensure the facility was providing the level and types of support and care needed for the resident population. The facility identified the following: Cardiopulmonary Resuscitation (CPR-emergency lifesaving procedure performed when the heart stops beating) with no further description on how to evaluate competency and/or effectiveness of the training.Life Enrichment Directors with no further description on how to evaluate competency and/or effectiveness of the training.Culture Change/Person Centered Care with no further description on how to evaluate competency and/or effectiveness of the training.Infection Control-Stewardship with no further description on how to evaluate competency and/or effectiveness of the training.C.N.A (no less than 12 per year) with no further description on how to evaluate competency and/or effectiveness of the training.Dementia Management with no further description on how to evaluate competency and/or effectiveness of the training.Disaster Planning and Procedures with no further description on how to evaluate competency and/or effectiveness of the training.Medication Administration for all Licensed Nurses and CMTs with no further description on how to evaluate competency and/or effectiveness of the training.Resident Assessments with no further description on how to evaluate competency and/or effectiveness of the training.Measurements for vital signs, urine, I&O, glucose, and catheter care with no further description on how to evaluate competency and/or effectiveness of the training.Caring for residents with Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), Dementia (progressive mental disorder characterized by failing memory, confusion), and Mental Illness with no further description on how to evaluate competency and/or effectiveness of the training.Specialized Care (undefined) with no further description on how to evaluate competency and/or effectiveness of the training.Unit Care including nonpharmacological interventions with no further description on how to evaluate competency and/or effectiveness of the training. The facility (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	failed to provide evidence of any staff competencies performed since their last annual survey dated 04/2025. Review of infection control related content in the assessment revealed the facility identified their common diagnoses as skin and soft tissue infections, respiratory infections, tuberculosis (communicable disease), urinary tract infections, infections with multi-drug-resistant organisms, septicemia (systemic infection), viral hepatitis (inflammatory condition of the liver, clostridium difficile (infection involving the colon), influenza (highly contagious viral infection), and scabies (contagious infestation of the skin by burrowing mites). The facility identified an average range/number of isolation/quarantine residents with active infection as one to three. The facility noted they would need to provide residents with identification and containment of infections and prevention of infections. The assessment contained a section for the facility to evaluate their infection prevention and control program, which included effective systems for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals that follow national standards, but the assessment lacked any evaluation, review, or development of their infection control program. (See F880, F881, F882, F883, and F887) Review of the Facility Assessment Policy and Tool dated [DATE] revealed the facility would conduct and document a facility wide assessment to determine what resources were necessary to care for its residents completely during both day-to-day operations and emergencies. The assessment will include staff competencies that were necessary to provide the level and types of care needed for the resident population. Individuals involved in creation of the assessment would include Administration, Environmental Operations Manager, Department Heads, and individual members of the direct care staff. The facility was also encouraged to seek input from residents, their representatives or families and consider information when formulating their assessment. The assessment would address infection control issues that required a change in infection prevention resources and methods.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. The facility reported a census of 34 residents. Based on interview and record review the facility failed to implement and maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program and plan, through the lack of effective involvement by governance and leadership. Administrative Staff A could not provide evidence the QAPI program was effective in the identification of quality concerns, when the current survey identified Immediate Jeopardy and Substandard Quality of Care. Findings included:- On 01/13/26 at 06:53PM Administrative Staff A brought the QAPI sign-in sheets to the surveyor. Review of the sign in sheets revealed the Director of Nursing did not attend the July 2025 through January 2026 meetings and the Medical Director had not attended quarterly. During an interview on 01/13/26 at 06:57 PM Administrative Staff A stated the facility did QAPI online on the computer and talked about the same thing every month, so she did not know how to print the prior agendas but pointed to the blank copy and stated it was the same agenda every month. Administrative Staff A stated that they had quarterly meetings, as they had QAPI monthly, but it was hit and miss on if the Medical Director attended as it depended on his schedule and when they had QAPI, but stated they had to have it by the 10th of every month. Administrative Staff A stated the plan had a place to put incidents and attach the summary of what it was. She said they did resident questions each month and went over survey or anything that they did not go over every month. Review of the QAPI Monthly blank answer form revealed the following QAPI format: An area for the facility name.A grey box with the following fillable areas: Date, Minute Recorded by Meeting CoordinatorAlso in the grey box was a section titled Meeting Purpose which had the following checkbox options:Scheduled, Resident Request, Guardian Request, IDT Member Req, Other, and a blank checkbox.The gray box contained a third area titled IDT Member Present for Meeting and had checkboxes for the following staff:Administrator, DON, RCC, Physician, Social Services, Other Nursing, Dietary Manager, Assistant Administrator, Guardian, Family Rep, Resident, MDS Coord., CP Coordinator, Pharmacy, Dietary Consultant, Financial, ADON, BOM, Activity Dir, Dietician, Antibiotic Stew, and two blank checkboxes.The next portion of the form revealed Best Practice Instructions which noted to assign which sections of the Health Services Review of IDT member to Audit each month. If noted during audit, sections are non-compliant, create action plan to correct. Review again during Monthly QAPI to ensure compliance is achieved for each section and fill box with color or mark as completed and in compliance. The form then contained the following areas:Physician VisitsBaseline and Annual EKG's (completed for all residents on psychotropic medications)Dental ServicesVision ServicesMammogramHearing ServicesInfluenza VaccinesRSV VaccinePneumovax(listed the CDC Guidelines)Covid VaccinesPodiatry ServicesColonoscopyReview of Monthly Wound ReportsReview of infection logInfection ControlAspiration List Review InstructionsMonthly Incident ReviewRequest for Physical TherapyRequest for Occupational TherapyRequest for Speech TherapyReview of Psychotropic, Antipsychotic, hypnotic, medications reviewReview of CathetersDischargesServices offered to residents upon dischargeMDS ReviewCare Plans Reviewed and updatedFacility medical equipment needsDNR ReviewPhysician Order Signature ReviewReview of User Defined AssessmentsReview Weight LossesReview Weight Gains Review of the facility provided Facility Assessment Tool revised 11/2025 revealed a section titled QAPI [Quality Assurance Performance Improvement] Program which indicated a QAPI meeting would be held monthly. The assessment tool stated the QAPI meeting is held monthly and attended by the Director of Nursing, Administrator, Business Office Manager, Activities Director, Medical Director, Therapy Director, Maintenance Director and Environmental Services Lead. The tool further indicated All staff is aware of when QAPI is held and welcome to attend. The meetings would be held to determine what things are working and what need improvement in the facility with resident care, staffing, maintenance, and all other areas. The facility would create policy improvement plans for problems identified that needed improvements. During the current survey Immediate Jeopardy was identified for (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the following regulations:Free of Accident Hazards/Supervision (Quality of Care- See F689)Pharmacy Services (See F755)Infection Control (See F880) And Substandard Quality of Care (SQC) identified in the following areas:Free of Accident Hazards/Supervision (Quality of Care- See F689)Influenza and Pneumococcal Immunizations (Infection Control- See F883)Activities Meet Interest/Needs of Each Resident (See F679) The facility could not provide evidence the QAPI program identified and/or addressed concerns to mitigate the onsite findings of immediate jeopardy and substandard quality of care. The facility provided a copy of the QAPI policy on 01/13/26. The facility provided policy was titled QAPI Plan and had an origination date of 05/14/21, revised 07/09/21. The policy included the guiding values or principles of QAPI plan included stewardship, integrity, respect, excellence, leadership, and personal growth. The plan provided guidance for the facility overall quality improvement program and noted quality assurance performance improvement principles will drive the decision making within the facility, and decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. The QAPI meeting would be held on a monthly basis. All department heads, the administrator, the director of nursing, antibiotic steward, infection control and prevention officer, medical director, consulting pharmacist would provide QAPI leadership by being on the QAPI committee. Records of the actions taken at each meeting would be kept using the attached form instruction for IDP/CP/QAPI QA Meetings. Minutes should document what was reviewed, issues/problems addressed, plan of correction, the monitory process and the results. At least quarterly, all disciplines should have a representative at the QAPI meetings. The policy noted the overview of the QAPI process was to: identify and use data to monitor facility performance; establish goals and threshold to measure performance; utilize residents, staff and family input; identify and prioritize problems and opportunities for improvement; systematically analyze underlying causes of systemic problems and adverse events; develop corrective action or performance improvement activities. The QAPI Plan would be reviewed annually by the RCMC Director of Organizational Development with input from facility Administrators and Directors of Nursing. The QAPI Plan noted the committee would review resident reported concerns, grievances, and/or resident council meeting to help identify issues. The Data and Statistics section noted the QAPI committee would review data for all areas of the facility to assure systems were being monitored and maintained to achieve the highest level of quality and listed the following reports the QAPI committee may use: Infection Control Log and Infection Prevention and Control ProgramWound ReportsAntibiotic Utilization ReportsCMS Quality Measures, CASPER Reports and any other data to measure the facilityIncident Report Log including, but not limited to, Falls, RN Investigation, Medication/Treatment omissions, Elopement or WanderingWeight Loss Reports at 30, 90, and 180 daysAdvanced care planning auditsMedication administration auditsMedication room audits

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. The facility reported a census of 34 residents. Based on interview and record review the facility failed to show evidence the Quality Assurance Performance Improvement (QAPI) program developed and implemented action plans to correct identified quality deficiencies cited on prior and current survey, lacked evidence the QAPI program were aware of the systemic issues which rose to the level of Immediate Jeopardy and Substandard Quality of Care on the current survey, and lacked evidence the QAPI program were monitoring facility practices to prevent adverse events. Findings included:- Review of the citations found on the prior recertification survey dated 04/16/25 revealed the facility was cited for deficient practice for the following regulations:F0580 (Notify of Changes (Injury/Decline/Room, etc.) at a DF0623 (Notice Requirements Before Transfer/Discharge) at a DF0625 (Notice of Bed Hold Policy Before/Upon Transfer) at a E*F0689 (Free of Accident Hazards/Supervision/Devices) at a D*F0727 (RN 8 Hrs/7 days/Wk, Full Time DON) at a F*F0730 (Nurse Aide Peform Review-12 hr/yr In-Service) at a F*F0744 (Treatment/Service for Dementia) at a D*F0755 (Pharmacy Services/Procedures/Pharmacist/Records) at a F*F0756 (Drug Regimen Review, Report Irregular, Act On) at a FF0760 (Residents are Free of Significant Med Errors) at a D*F0761 (Label/Store Drugs and Biologicals) at a EF0801 (Qualified Dietary Staff) at a EF0812 (Food Procurement,Store/Prepare/Serve-Sanitary) at a F*F0867 (QAPI/QAA Improvement Activities) at a F*F0868 (QAA Committee) at a F*F0880 (Infection Prevention & Control) at a F*F0882 (Infection Preventionist Qualifications/Role) at a F*F0883 (Influenza and Pneumococcal Immunizations) at a E*F0947 (Required In-Service Training for Nurse Aides) at a FThe asterisk indicates the deficient practice was identified on the current survey, which concluded on 01/14/26. On 01/13/26 at 06:53PM Administrative Staff A brought the QAPI sign-in sheets to the surveyor. Review of the sign in sheets revealed the Director of Nursing did not attend the July 2025 through January 2026 meetings and the Medical Director had not attended quarterly. During an interview on 01/13/26 at 06:57 PM Administrative Staff A stated the facility did QAPI online on the computer and talked about the same thing every month, so she did not know how to print the prior agendas, but pointed to the blank copy and stated it was the same agenda every month. Administrative Staff A stated that they had quarterly meetings, as they had QAPI monthly, but it was hit and miss on if the Medical Director attended as it depended on his schedule and when they had QAPI, but stated they had to have it by the 10th of every month. Administrative Staff A stated the plan had a place to put incidents and attach the summary of what it was. She said they did resident questions each month and went over survey or anything that they did not go over every month. Review of the QAPI Monthly blank answer form revealed the following QAPI format:An area for the facility name.A grey box with the following fillable areas: Date, Minute Recorded by Meeting CoordinatorAlso in the grey box was a section titled Meeting Purpose which had the following checkbox options:Scheduled, Resident Request, Guardian Request, IDT Member Req, Other, and a blank checkbox.The gray box contained a third area titled IDT Member Present for Meeting and had checkboxes for the following staff:Administrator, DON, RCC, Physician, Social Services, Other Nursing, Dietary Manager, Assistant Administrator, Guardian, Family Rep, Resident, MDS Coord., CP Coordinator, Pharmacy, Dietary Consultant, Financial, ADON, BOM, Activity Dir, Dietician, Antibiotic Stew, and two blank checkboxes.The next portion of the form revealed Best Practice Instructions which noted to assign which sections of the Health Services Review of IDT member to Audit each month. If noted during audit, sections are non-compliant, create action plan to correct. Review again during Monthly QAPI to ensure compliance is achieved for each section and fill box with color or mark as completed and in compliance. The form then contained the following areas:Physician VisitsBaseline and Annual EKG's (completed for all residents on psychotropic medications)Dental ServicesVision ServicesMammogramHearing ServicesInfluenza VaccinesRSV VaccinePneumovax(listed the CDC Guidelines)Covid VaccinesPodiatry ServicesColonoscopyReview (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of Monthly Wound ReportsReview of infection logInfection ControlAspiration List Review InstructionsMonthly Incident ReviewRequest for Physical TherapyRequest for Occupational TherapyRequest for Speech TherapyReview of Psychotropic, Antipsychotic, hypnotic, medications reviewReview of CathetersDischargesServices offered to residents upon dischargeMDS ReviewCare Plans Reviewed and updatedFacility medical equipment needsDNR ReviewPhysician Order Signature ReviewReview of User Defined AssessmentsReview Weight LossesReview Weight Gains Review of the facility provided Facility Assessment Tool revised 11/2025 revealed a section titled QAPI [Quality Assurance Performance Improvement] Program which indicated a QAPI meeting would be held monthly. The assessment tool stated the QAPI meeting is held monthly and attended by the Director of Nursing, Administrator, Business Office Manager, Activities Director, Medical Director, Therapy Director, Maintenance Director and Environmental Services Lead. The tool further indicated All staff is aware of when QAPI is held and welcome to attend. The meetings would be held to determine what things are working and what need improvement in the facility with resident care, staffing, maintenance, and all other areas. The facility would create policy improvement plans for problems identified that needed improvements. During the current survey Immediate Jeopardy was identified for the following regulations:Free of Accident Hazards/Supervision (Quality of Care- See F689)Pharmacy Services (See F755)Infection Control (See F880)And Substandard Quality of Care (SQC) identified in the following areas:Free of Accident Hazards/Supervision (Quality of Care- See F689)Influenza and Pneumococcal Immunizations (Infection Control- See F883)Activities Meet Interest/Needs of Each Resident (See F679) The facility could not provide evidence the QAPI program monitored facility systemic concerns which were cited on prior surveys in order to correct and mitigate the onsite findings of immediate jeopardy and substandard quality of care found on the current survey. The facility provided a copy of the QAPI policy on 01/13/26. The facility provided policy was titled QAPI Plan and had an origination date of 05/14/21, revised 07/09/21. The policy included the guiding values or principles of QAPI plan included stewardship, integrity, respect, excellence, leadership, and personal growth. The plan provided guidance for the facility overall quality improvement program and noted quality assurance performance improvement principles will drive the decision making within the facility, and decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. The QAPI meeting would be held on a monthly basis. All department heads, the administrator, the director of nursing, antibiotic steward, infection control and prevention officer, medical director, consulting pharmacist would provide QAPI leadership by being on the QAPI committee. Records of the actions taken at each meeting would be kept using the attached form instruction for IDP/CP/QAPI QA Meetings. Minutes should document what was reviewed, issues/problems addressed, plan of correction, the monitory process and the results. At least quarterly, all disciplines should have a representative at the QAPI meetings. The policy noted the overview of the QAPI process was to: identify and use data to monitor facility performance; establish goals and threshold to measure performance; utilize residents, staff and family input; identify and prioritize problems and opportunities for improvement; systematically analyze underlying causes of systemic problems and adverse events; develop corrective action or performance improvement activities. The QAPI Plan would be reviewed annually by the RCMC Director of Organizational Development with input from facilty Administrators and Directors of Nursing. The QAPI Plan noted the committee would review resident reported concerns, grievances, and/or resident council meeting to help identify issues. The Data and Statistics section noted the QAPI committee would review data for all areas of the facilty to assure systems were being monitored and maintained to achieve the highest level of quality and listed the following reports the QAPI committee may use:Infection Control Log and Infection Prevention and Control ProgramWound ReportsAntibiotic Utilization ReportsCMS Quality Measures, CASPER Reports and any other data to measure the facilityIncident Report Log including, but not limited to, Falls, RN Investigation, Medication/Treatment omissions, Elopement or Wandering.Weight Loss Reports at 30, 90, and 180 days.Advanced care planning auditsMedication administration auditsMedication room audits

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility reported a census of 34 residents. Based on interview and record review the facility failed to ensure the required members attended the Quality Assurance Performance Improvement (QAPI) meetings at least quarterly, as required by federal regulation. This failure had the ability to affect all 34 residents. Findings included:- Review of the facility provided Sign in sheets, which appeared to be hand drawn with columns and lines, and had the following handwritten headings: Date, Print Name, Signature, and Title. For the QAPI JUNE handwritten on the top right of the page revealed the following attended:04/10/25 Therapy Staff M04/10/25 Dietary Manager JJ04/10/25 Certified Nurse Aide (CNA) N (served as SSD at the time)04/10/25 Medical Records II04/10/25 Administrative Nurse B04/10/25 Maintenance Staff JThe 04/10/25 meeting lacked evidence the Administrator, Pharmacy, or Medical Director attended. For the QAPI - May 2025 handwritten on the top right of the page revealed the following attended:05/09/25 Administrative Staff A05/09/25 Business Office Manager (BOM) L05/09/25 Administrative Nurse B05/09/25 Dietary Manager JJ05/09/25 Activities Director E For the QAPI - April handwritten on the top right of the page revealed the following attended:06/11/25 Medical Records II06/11/25 Activities Director E06/11/25 Administrative Nurse B06/11/25 Dietary Manager JJ06/11/25 Administrative Staff A06/11/25 BOM L06/11/25 Medical Director G For the QAPI July handwritten on the top right of the page revealed the following attended:07/08/25 Activities Director E07/08/25 BOM L07/08/25 Administrative Staff AThe 07/08/25 meeting lacked evidence the Director of Nursing, Social Services, Therapy, Dietary, Pharmacy, or Medical Director attended. For the QAPI August handwritten on the top right of the page revealed the following attended:08/07/25 Administrative Staff A08/07/25 Activities Director E08/07/25 BOM LThe 08/07/25 meeting lacked evidence the Director of Nursing, Social Services, Therapy, Dietary, Pharmacy, or Medical Director attended. For the QAPI Sept handwritten on the top right of the page revealed the following attended:09/09/25 Administrative Staff A09/09/25 Activities Director E09/09/25 BOM LThe 09/09/25 meeting lacked evidence the Director of Nursing, Social Services, Therapy, Dietary, Pharmacy, or Medical Director attended. For the QAPI Oct handwritten on the top right of the page revealed the following attended:10/07/25 Activities Director E10/07/25 BOM L10/07/25 Dietary Manager H10/07/25 Social Services Designee (SSD) D10/07/25 Administrative Staff AThe 10/07/25 meeting lacked evidence the Director of Nursing, Therapy, or Medical Director attended. For the QAPI Nov. handwritten on the top right of the page revealed the following attended:11/06/25 Administrative Staff A11/06/25 BOM L11/06/25 Dietary Manager H11/06/25 (dated, but lacked a name, signature, and title)11/06/25 SSD D11/06/25 Activities Director EThe 11/06/25 meeting lacked evidence the Director of Nursing, Therapy, or Medical Director attended. For the QAPI Dec. handwritten on the top right of the page revealed the following attended:12/09/25 Administrative Staff A12/09/25 SSD D12/09/25 BOM L12/09/25 Activities Director E12/09/25 Dietary Manager HThe 11/06/25 meeting lacked evidence the Director of Nursing, Therapy, or Medical Director attended. For the QAPI Jan. handwritten on the top right of the page revealed the following attended:01/09/26* BOM L01/09/26* SSD D01/09/26 Dietary Manager H01/09/26* Activities Director E01/09/26 Administrative Staff A* Indicated the date was handwritten over in the year to make it 26, but still legible was the year 25.The 01/09/26 meeting lacked evidence the Director of Nursing, Therapy, Pharmacy, or Medical Director attended. From 04/10/25 through 01/09/26 the Medical Director attended one meeting (on 06/11/25) in ten months, indicating the failure to attend quarterly. From 04/10/25 through 01/09/26 the Director of Nursing attending three meetings (04/10/25, 05/09/25, and 06/11/25) out of the 10 months offered, indicating the failure to attend at least quarterly. On 01/13/26 at 06:53PM Administrative Staff A brought a copy of the QAPI sign-in sheets to the surveyor. During an interview on 01/13/26 at 06:57 PM Administrative Staff A stated the facility did QAPI online on the computer and talked about the same thing every month, so she did (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not know how to print the prior agendas but pointed to the blank copy and stated it was the same agenda every month. Administrative Staff A stated that since they attended online, she would forget to send the sign in sheet to the medical director to sign. Administrative Staff A stated that they had quarterly meetings, as they had QAPI monthly, but it was hit and miss on if the Medical Director attended as it depended on his schedule and when they had QAPI, but stated they had to have it by the 10th of every month. The facility provided a copy of the QAPI policy on 01/13/26. The facility provided policy was titled QAPI Plan and had an origination date of 05/14/21, revised 07/09/21. The policy included the guiding values or principles of QAPI plan included stewardship, integrity, respect, excellence, leadership, and personal growth. The plan provided guidance for the facility overall quality improvement program and noted quality assurance performance improvement principles will drive the decision making within the facility, and decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. The QAPI meeting would be held on a monthly basis. All department heads, the administrator, the director of nursing, antibiotic steward, infection control and prevention officer, medical director, consulting pharmacist would provide QAPI leadership by being on the QAPI committee. At least quarterly, all disciplines should have a representative at the QAPI meetings. The QAPI Plan would be reviewed annually by the RCMC Director of Organizational Development with input from facility Administrators and Directors of Nursing. The QAPI Plan noted the committee would review resident reported concerns, grievances, and/or resident council meeting to help identify issues.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. The facility had a census of 34 residents with 14 in the sample. Based on observation, interview, and record review the facility failed to develop a program for antibiotic stewardship and failed to implement a system to monitor antibiotic use. Record review revealed the facility failed to follow up on prescribed antibiotics, the infectious organisms, and/or the use of antibiotics for residents identified with multi-drug-resistant organisms including methicillin-resistant Staphylococcus aureus (MRSA - per The Centers for Disease Control and Prevention MRSA is a type of staphylococcus that can be resistant to several antibiotics, which anyone can get or carry. The risk for MRSA increases for people in nursing homes, crowded areas, and/or unhygienic places) and multi-drug resistant ESBL (Extended-Spectrum Beta-Lactamases (ESBLs) are enzymes produced by certain bacteria, primarily Escherichia coli (E. coli)). These failures led to multiple resident hospitalizations/rehospitalizations, the amputation of an infected left lower extremity, chronic wounds that were slow or non-healing, and admission to hospice related to septicemia (systemic infection of the blood). Findings included:- Review of the Facility Assessment Tool dated 11/18/25 revealed the facility was licensed for 45 beds, with an average census of 32 residents. The facility identified their common diagnoses related to infectious disease as skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections (communicable disease that effects the lungs), infections with multi-drug-resistant organisms, septicemia (systemic infection of the blood), viral hepatitis (inflammatory condition of the liver), clostridium difficile (infection of the colon), influenza (highly contagious viral infection), and scabies (contagious infestation of the skin by burrowing mites). The facility identified an average range/number of isolation/quarantine residents with active infection as one to three. The facility noted they would need to provide residents with identification and containment of infections and prevention of infections. The assessment contained a section for the facility to evaluate their infection prevention and control program, which included effective systems for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals that follow national standards, but the assessment lacked any evaluation, review, or development of their infection control program. Review of the facility provided, electronic charting system generated, Infection Surveillance Monthly Report dated 01/12/26 revealed the facility had 25 total infections between 07/01/25 and 01/12/26. The report indicated no infections were present in November and December of 2025 and January 2026. The report contained a Summary by Infection Category, which included blood/systemic, bone/joint, cardiovascular, and ear/nose/mouth/throat that were all blank. Review of the Order Listing Report generated 01/12/26, with dates ranging from 06/01/25 to 01/12/26 revealed 48 separate physician ordered antibiotics and/or infection related treatments for 18 residents, who resided throughout the facility and included cellulitis, upper respiratory infections, wound infections, and methicillin-resistant Staphylococcus aureus (MRSA - per The Centers for Disease Control and Prevention MRSA is a type of staphylococcus that can be resistant to several antibiotics, which anyone can get or carry. The risk for MRSA increases for people in nursing homes, crowded areas, and/or unhygienic places) of an unknown location. Based on observation, interview, and record review the facility failed to ensure Resident (R) 11 who entered the facility with a urinary catheter received the appropriate treatment and services to prevent urinary tract infections and other catheter associated concerns of infected wounds to both inner thighs without the use of an anchor for the catheter. The resident admitted to the hospital on multiple occasions, received intravenous antibiotics, had a diagnosis of MRSA and returned to the facility with no monitoring or intervention to prevent further infection. Based on observation, interview, and record review the facility failed to implement their infection control and wound care policy/procedures when Resident (R) 9 was diagnosed with cellulitis (skin infection caused by bacteria), received antibiotic therapy on 08/21/25, and the facility failed to document the effectiveness of the antibiotics, any ongoing signs/symptoms of infection/antibiotic use, and the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident's reaction to the infection/antibiotic use. On 08/23/25, while still on antibiotics for cellulitis the resident had a change in mental status and refused transport to the hospital. The facility failed to document continued monitoring of the resident after the resident had a change in status. The facility further failed to document any education provided or reapproach provided after the resident's refusal to be seen. On 09/05/25 the facility notified the resident's provider the resident refused labs the prior day, with no follow up to the resident's refusal documented, no attempts to reapproach the resident, no education provided on the seriousness of obtaining the lab and/or additional monitoring of the resident. The resident's record continued to lack evidence the antibiotics started on 08/21/25 were effective and/or continued monitoring for the effectiveness in treating the infection. On 09/09/25 the resident asked to be transported to the hospital due to pain in the left lower extremity. While at the hospital the resident was diagnosed with extensive infection throughout the left lower extremity and ultimately experienced actual harm when his left lower extremity required amputation. Upon arrival back to the facility the facility failed to implement enhanced barrier precautions and/or wound care and days later the resident readmitted to the hospital for treatment of further infection to the stump. Based on observation, interview, and record review the facility failed to ensure effective interventions, accurate assessments, and consistent monitoring, to prevent the development of a facility acquired stage 3 (full thickness pressure injury extending through the skin into the tissue below) pressure ulcer/injury of the sacrum (large triangular bone/area between the two hip bones) for dependent and at risk Resident (R)7, who required hospitalization for wound care and intravenous antibiotics for sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body). During an interview and review of infection control records on 01/12/26 at 03:44 PM Consultant Nurse C reported she found an Infection Control Binder dated 2024 and one dated 2025, which lacked any tracking of infections, antibiotic review, and/or infectious agent or organism involved. Consultant Nurse C provided an electronic charting software generated report titled Infection Surveillance Monthly Report indicating rises and falls acquired infections from February 2025 to January 2026. Consultant Nurse C stated the chart indicated the facility was possibly tracking and trending infections, however it lacked specific locations of the infections (resident room location in the building), infectious organisms, notation that at least one resident had a catheter and associated urinary tract infection, system for recording any infection control incidents with follow up/actions taken and/or where the infection originated (wound, dental, respiratory tract, etc.) Review of the Antibiotic Stewardship Program policy dated 06/29/23 revealed the facility would optimize antibiotic use in the nursing home and reduce unnecessary use of laboratory tests and antibiotics using a systemic approach. The antibiotic stewardship program would be run by the facility antibiotic steward, who would lead the antibiotic stewardship team (compromised of at least the Director of Nursing, a nurse with administrative duties, and a charge nurse. The antibiotic stewardship program would use a systematic evaluation of ongoing treatment. The facility would track and monitor antibiotic prescribing practices and resistance patterns among its residents. The antibiotic steward would review and generate an infection log in the facility electronic charting system and place it in the antibiotic stewardship binder removing the weekly reports each month. A report on antibiotic use and resistance would be reported to the monthly quality assurance committee, physicians, prescribing practitioners, pharmacy consultant, facility nurses, and other relevant staff. All antibiotics would be entered into physician orders, infection control tracking, and have an infection follow up completed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. The census totaled 34 with 14 in the sample. Based on observation, interview, and record review the facility failed to provide evidence they designated one infection preventionist who was qualified by education, training, experience and/or certification that worked at least part time on the facility infection control program and completed specialized training in infection prevention and control. This failure created the likelihood for the transmission of infectious agents, subsequent infection, and caused actual severe infection with significant outcomes. Findings included:- The facility identified Administrative Nurse B as the current Infection Preventionist. The facility failed to provide evidence Administrative Staff B was qualified to fill the role by education, training, experience or certification. Review of the Facility Assessment Tool dated 11/18/25 revealed the facility was licensed for 45 beds, with an average census of 32 residents. The facility identified their common diagnoses related to infectious disease as skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections, infections with multi-drug-resistant organisms, septicemia (systemic infection of the blood), viral hepatitis (inflammatory condition of the liver), clostridium difficile (infection of the colon), influenza (highly contagious viral infection), and scabies (contagious infestation of the skin by burrowing mites). The facility identified an average range/number of isolation/quarantine residents with active infection as one to three. The facility noted they would need to provide residents with identification and containment of infections and prevention of infections. The assessment contained a section for the facility to evaluate their infection prevention and control program, which included effective systems for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals that follow national standards, but the assessment lacked any evaluation, review, or development of their infection control program. Observations on 01/11/26 and 01/12/26 revealed laundry on resident floors with staff transporting the items down a hallway with other residents around with no infection control practices in place. Staff transported mechanical lifts from resident room to resident room with no cleaning in between residents and dusty footprints present along the bases. Upon initial observation only one room had signage indicating the use of 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) and/or Personal Protective Equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves), and after entrance approximately five additional rooms were noted to have EBP signage and PPE located outside of the rooms. Resident's who lacked EBP upon entrance to the facility had current wounds, indwelling catheters, and known multidrug resistant organism infections. Staff carried clear bags with visibly soiled briefs swinging down the hall and into resident rooms, while dragging the thin bag along the wood handrails, which were present in the hallways for all residents to use. Review of the facility provided, electronic charting system generated, Infection Surveillance Monthly Report dated 01/12/26 revealed the facility had 25 total infections between 07/01/25 and 01/12/26. The report indicated no infections were present in November and December 0f 2025 and January 2026. The report contained a Summary by Infection Category, which included blood/systemic, bone/joint, cardiovascular, and ear/nose/mouth/throat that were all blank. Review of the Order Listing Report generated 01/12/26, with dates ranging from 06/01/25 to 01/12/26 revealed 48 separate physician ordered antibiotics and/or infection related treatments for 18 residents, who resided throughout the facility and included cellulitis, upper respiratory infections, wound infections, and methicillin-resistant Staphylococcus aureus (MRSA - per The Centers for Disease Control and Prevention MRSA is a type of staphylococcus that can be resistant to several antibiotics, which anyone can get or carry. The risk for MRSA increases for people in nursing homes, crowded areas, and/or unhygienic places) of an unknown location. The facility lacked any formal tracking and trending of resident infections. The (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility lacked documentation of an antibiotic stewardship program. Review of resident electronic health records regarding infections from June 2025 to January 2026 revealed residents had various infections with significant outcomes (see F880, F684, F686, and 690). During an interview on 01/11/26 at 05:53 PM with Certified Medication Aide (CMA) BB she stated the facility was often short staffed. She reported when the facility was short staffed, care things were missed, like checking and showering residents. CMA BB stated before today the facility only had one resident who required PPE, including gown, mask, and gloves with cares due to an infection, but reported she was just told staff needed to wear the same PPE for emptying catheters and for residents with wounds. CMA BB reported if a resident had MRSA that was typically the reason staff were instructed to use gowns with resident cares before today (01/11/26). CMA BB also verified the additional PPE and EBP signs placed on both the east and west units after the initial tour were just placed today (01/11/26). During an interview and review of infection control records on 01/12/26 at 03:44 PM Consultant Nurse C reported she found an Infection Control Binder dated 2024 and one dated 2025, which lacked any tracking of infections, antibiotic review, and/or infectious agent or organism involved. Consultant Nurse C provided an electronic charting software generated report titled Infection Surveillance Monthly Report indicating rises and falls acquired infections from February 2025 to January 2026. Consultant Nurse C stated the chart indicated the facility was possibly tracking and trending infections, however it lacked specific locations of the infections (resident room location in the building), infectious organisms, notation that at least one resident had a catheter and associated urinary tract infection, system for recording any infection control incidents with follow up/actions taken and/or where the infection originated (wound, dental, respiratory tract, etc.) During an interview regarding the facility water maintenance program/legionella (Legionella is a bacterium which can cause pneumonia in vulnerable populations) prevention on 01/12/2026 at 04:03 PM with Maintenance Staff J and Administrative A revealed the facility did not have any evidence of testing for legionella as stated in their prior survey plan of correction/water management plan provided by the facility. Maintenance Staff J stated he did flushes (did not identify what was flushed) back in August or September, however then stated he did not have a log or documentation regarding flushing the water system. Maintenance Staff J stated he was unaware he needed to log any flushes of the water system that he performed and stated he documented water temperatures most days. Administrative Staff A interrupted and instructed Maintenance Staff J that he needed to have documentation for any of the water management tasks he performed. On 01/12/26 Administrative Staff A stated she was looking for documentation, which indicated Administrative Nursing Staff B (the facility's self-reported IP) completed any specialized training in infection prevention and control. During an interview with Administrative Staff A at approximately 07:16 PM on 01/13/26 she reported the facility was unable to locate any documentation, which indicated Administrative Nursing Staff B completed specialized training in infection prevention and control. Consultant Nurse C state she was unaware that Administrative Staff A did not have the documentation available. During an interview with Consultant Nurse C at 05:45 PM on 01/14/26 she reported the facility Director of Nursing or Social Services would complete the influenza immunization consent/declinations. She stated it was the responsibility of Administrative Nursing Staff B to oversee the immunizations and ensure they were administered. Once resident consent for the immunizations were obtained, she expected staff to administer the immunization and for staff to document the immunization administration in the Electronic Health Record. Review of the Infection Preventionist Policy dated 05/14/24 revealed the facility would employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program, which would include an antibiotic stewardship program. The facility would base the number of hours the IP designated to the program on the facility assessment. The policy stated the IP would be sufficiently trained in infection prevention and control and would obtain specialized training or educational programs prior to assuming the role and would provide evidence of training through a certificate of completion or equivalent documentation. The responsibility of the IP (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	included developing an infection control program, establish facility wide systems for prevention, identification, reporting and control of infections. The IP would further provide oversight of ensuring an antibiotic stewardship program, oversight of resident care activities, and approve infection prevention training topics for staff. The IP would participate on the quality assessment and assurance committee and report their activities to the committee.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. The census totaled 34 with 14 in the sample. Based on interview, and record review the facility failed to provide evidence they offered influenza (highly contagious viral infection) immunizations to residents for the 2025 influenza season, when the vaccines were made available for the year and/or beginning approximately October 1st, 2025. The facility further failed to provide signed consents/declinations and/or evidence of vaccination administration related to the influenza and/or pneumococcal (type of bacterial infection) vaccine for Residents (R) 2, R6, R7, R11, and R16. Findings included:- Review of all resident Electronic Health Records, under the immunizations tab on 01/12/26 for influenza immunizations lacked evidence residents were offered and/or received influenza immunizations at the facility during the 2025 season. Resident charts either reflected the 2024 dates or noted refusals with no dates. Upon request on 01/14/26 at 10:32 AM, the facility was unable to provide influenza, pneumococcal, and Covid-19 vaccination signed consents or declinations or documentation of vaccination administrations for influenza and/or pneumococcal vaccinations for R2, R6, R7, R11, and R16. On 01/14/26 at 12:13 PM, Consultant Nurse C stated she was unable to find requested immunization documentation. During an interview with Consultant Nurse C at 05:45 PM on 01/14/26 she reported the facility Director of Nursing or Social Services would complete the influenza immunization consent/declinations. She stated it was the responsibility of Administrative Nursing Staff B to oversee the immunizations and ensure they were administered. Once resident consent for the immunizations were obtained, she expected staff to administer the immunization and for staff to document the immunization administration in the Electronic Health Record. Review of the 05/14/24 Influenza and Pneumococcal Immunizations policy revealed the facility would ensure all residents residing in the facility were offered influenza and pneumococcal immunizations to prevent infection and the spread of communicable diseases. The resident and/or their legal representative would be informed influenza immunizations were provided yearly (between 10/01 and 03/31) unless the immunizations were medically contraindicated, the facility had evidence the resident was already immunized during the time period, or the resident/legal representative refused the immunization.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. The facility census totaled 34 with 14 in the sample. Based on interview and record review the facility failed to ensure staff had the appropriate competencies and skill sets related to the facility Quality Assurance and Performance Improvement (QAPI) program to provide nursing and related services to ensure staff were aware of goals and aspects of the program that assured resident safety and attained or maintained the highest practicable physical, mental and psychosocial wellbeing of each resident as determined by resident assessments, plans of care and utilizing the facility assessment. Findings included:- The facility failed to provide evidence of staff competency evaluations from Administrative Staff A as requested on 01/11/26 and again on 01/12/26. During an interview on 01/26/25 with Consultant Staff X at 03:51 PM she stated she did not have any proof the facility performed competency evaluations with certified staff. See F865, F867. and F868 for outcomes related to the facility's lack of QAPI training and follow up competency evaluations to ensure staff were aware of the facility goals, essential elements of the program. and input into training content updates. Review of the Sufficient Staff Policy dated 05/15/24 revealed the facility would provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility census totaled 34 with 14 in the sample. Based on interview and record review the facility failed to ensure measure the adequacy of any in-service training provided to staff by the failure to evaluate competencies and skill sets of Certified Nurse Aides (CNAs) to ensure the implementation of interventions necessary to meet resident's needs and as identified in the facility assessment. Findings included:- The facility failed to provide evidence of competency evaluations for CNAs from Administrative Staff A as requested on 01/11/26 and again on 01/12/26. During an interview on 01/26/25 with Consultant Staff X at 03:51 PM she stated she did not have any proof the facility performed competency evaluations with certified staff. Review of the Sufficient Staff Policy dated 05/15/24 revealed the facility would provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 14 residents with seven residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to respond to and maintain medication regimen reviews (MRR) conducted by the Consultant Pharmacist (CP) for R1, R32, R3, and R24. Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The admission Minimum Data Set (MDS) dated 03/17/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 had no behaviors. R1 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), and anticonvulsant (a class of medications used to treat seizures) medications. R1 received antipsychotic medications on a routine basis only and a gradual dose reduction (GDR) had not been attempted. The Quarterly MDS dated 12/02/25 documented R1 had a BIMS score of nine, which indicated moderate cognitive impairment. R1 had no behaviors. R1 received antipsychotic, antianxiety (a class of medications that calm and relax people), antidepressant, diuretic (a class of medication to promote the formation and excretion of urine), and hypoglycemic (a class of medications used to lower blood sugar levels). R1 received antipsychotic medications on a routine basis only and a gradual dose reduction had not been attempted. The Psychotropic Drug Use Care Area Assessment (CAA) dated 03/29/25, lacked an analysis of findings. R1's 08/11/25 Care Plan last revised 12/09/25, documented R1 received medication for bipolar depression. The Care Plan documented the following interventions:08/12/25- Staff administered antidepressant medications as ordered by physician and monitored/documented side effects and effectiveness every shift.08/12/25- Staff monitored/documented/reported as needed (PRN) adverse reactions to antidepressant therapy. R1's 8/11/25 Care Plan last revised 08/12/25, documented R1 used lorazepam (antianxiety medication) to decrease anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Care Plan documented the following interventions:08/12/25- Staff administered antianxiety medications as ordered by physician and monitored for side effects and effectiveness every shift.08/12/25- Staff monitored/documented/reported PRN any adverse reactions to antianxiety therapy.08/12/25- Staff monitored/recorded occurrences of target behavior symptoms and documented per facility protocol. R1's 08/11/25 Care Plan last revised 12/09/25, documented R1 took antipsychotic medications. The Care Plan documented the following interventions:08/12/25- Staff administered psychotropic (alters mood or thought) medications as ordered by physician and monitored for side effects and effectiveness every shift.08/12/25- Staff consulted with pharmacy and the medical doctor to consider dosage reduction when clinically appropriate at least quarterly.08/12/25- Staff discussed with the medical doctor and family the ongoing need of medication. Staff reviewed behaviors/interventions, alternative therapies attempted, and their effectiveness per facility policy. R1's EMR revealed the following Physician Orders: An order with a start date of 04/08/25, for olanzapine (antipsychotic medication) five milligrams (mg) at bedtime for bipolar disorder. An order with a start date of 05/01/25, for quetiapine fumarate (antipsychotic medication) 150 mg twice a day for bipolar disorder. An order with a start date of 05/05/25, for lorazepam (antianxiety medication) 0.5 mg three times a day for anxiety disorder. An order with a start date of 08/18/25, for Remeron (antidepressant medication) 15 mg at bedtime for depression. Review of R1's Pharmacy Review Notes from March 2025 to December 2025 revealed the following (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CP notes: 03/10/25- see report. 07/07/25- R1 received Trazodone 50 mg nightly. Please consider a dosage reduction to 25 mg nightly or document a clinical rationale for continuing the current dose. 12/14/25- see report. There was a lack of evidence of a medication regimen review for August 2025 and November 2025. Upon request, the facility was unable to provide the MRR or physician response to MRR for March 2025, July 2025, and December 2025. On 01/13/25 at 01:53 PM, R1 sat in her wheelchair in her room. She appeared to be upset and talking to herself. On 01/06/25 at 03:55 PM, Consultant Pharmacist (CP) EE stated she took over as the CP in November 2025. She stated she emailed the facility on 11/14/25 to inform the facility of the change and to set up a date for an onsite visit. She stated she emailed the facility again on 11/23/25 and 12/14/25. Consultant Pharmacist EE stated she completed the MRRs and GDRs for the facility and sent them in emails. She stated she never received a response to any of her emails from the facility. She stated she had never been to the facility for an onsite visit. On 01/13/26 at 03:31 PM, Administrative Staff A stated she found a pharmacy review book that had pharmacy reviews in them, but they were blank. She stated she would continue to look for the completed pharmacy reviews. On 01/14/26 at 12:18 PM, Consultant Nurse C stated she was unable to find any GDRs or rationales. On 01/14/26 at 05:45 PM, Consultant Nurse C stated the director of nursing (DON) was responsible for pharmacy reviews after the pharmacy representative completed the review and put their recommendations in the monthly report. She stated she expected the DON to open the reviews, and the administrator should be reviewing them too. Consultant Nurse C stated the DON took the pharmacy reviews, completed the nursing recommendations, and sent the other recommendations to the physician. She stated the facility was unable to locate any pharmacy reviews with physician response outside of the ones scanned into the EMR. The facility's Medication Regiment Review Policy last revised 06/26/24, directed the pharmacist documented electronically that each medication regimen review had been completed. The pharmacist either documented that no irregularity was identified or the nature of the identified irregularities. The pharmacist communicated any irregularities to the facility in written communication to the attending physician, the facility's medical director, and the DON. The policy directed written communications from the pharmacist became a permanent part of the resident's medical record. Facility staff acted upon all recommendations according to procedures for addressing medication regimen review irregularities. - R32 admitted to the facility on [DATE]. R32's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI-an injury to the brain caused by external forces) with loss of consciousness, adult failure to thrive, other seizure (violent involuntary series of contractions of a group of muscles), major depressive disorder (major mood disorder), and generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R32's admission Minimum Data Set (MDS) dated 08/24/25, documented R32 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. R1 had no falls since admission. R32 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and anticonvulsant (a class of medications used to treat seizures) medications. R32 received antipsychotic medications on a routine basis only and a gradual dose reduction (GDR) had not been attempted. R32's Quarterly MDS dated 11/04/25, documented a BIMS was not conducted due to R32 being rarely/never understood. R32 received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. R32 received antipsychotic medications on a routine basis only and a GDR had not been attempted. The Psychotropic (alters mood or thought) Drug Use Care Area Assessment (CAA) dated 08/24/25, documented R32 had no adverse effects during the lookback period. R32's 10/31/25 Care Plan last revised 11/20/25, documented R32 used antianxiety medications related to anxiety disorder. The Care Plan documented the following interventions:11/19/25- Staff administered antianxiety medications as ordered by physician and monitored for side effects and effectiveness every shift.11/19/25- Staff monitored/recorded (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occurrence for the target behavior symptoms. R32's 11/19/25 Care Plan documented R32 used psychotropic medications. The Care Plan documented the following interventions:11/19/25- Staff administered psychotropic medications as ordered by physician and monitored for side effects and effectiveness every shift.11/19/25- Staff consulted with pharmacy and the medical doctor to consider a dosage reduction when clinically appropriate at least quarterly.11/19/25- Staff discussed with medical doctor and family the ongoing need for the use of medication. Staff reviewed behaviors/interventions, alternate therapies attempted, and their effectiveness as per facility policy.11/20/25- Staff attempted medication adjustments, monitored R32, and notified the physician of any effects. R32's 11/19/25 Care Plan documented R32 used antidepressant medications. The Care Plan documented the following interventions:11/19/25- Staff administered antidepressant medications as ordered by physician and monitored/documented side effects and effectiveness every shift.11/19/25- Staff monitored/documented, reported as needed (PRN) any adverse reactions to antidepressant therapy. R32's EMR revealed the following Physician Orders: An order with a start date of 08/19/25, for quetiapine fumarate (antipsychotic medication) 100 milligrams (mg) at bedtime for anxiety disorder. An order with a start date of 10/17/25, for lorazepam 2 mg/milliliters (mL) give 0.5 mL every four hours as needed for anxiety/agitation. An order with a start date of 10/29/25, for lorazepam 0.5 mg two times a day related to anxiety disorder. An order with a start date of 11/21/25, for duloxetine hydrochloride 60 mg one time a day for anxiety. An order with a start date of 11/24/25, for quetiapine fumarate 50 mg in the morning for diffuse TBI and anxiety disorder. An order with a start date of 12/19/25, for trazodone 25 mg at bedtime for sleep. Review of R32's Pharmacy Review Notes from September 2025 to December 2025 revealed the following CP notes: 09/12/25 - see report. 12/14/25 - see report. Upon request, the facility was unable to provide the MRR or physician response to MRR for September 2025 and December 2025. On 01/14/26 at 10:33 AM, R32 self-propelled in his wheelchair down the hallway towards his room. An unidentified female staff member stated to another staff member that R32 wanted to lay down for a bit. On 01/06/25 at 03:55 PM, Consultant Pharmacist EE stated she took over as the CP in November 2025. She stated she emailed the facility on 11/14/25 to inform the facility of the change and to set up a date for an onsite visit. She stated she emailed the facility again on 11/23/25 and 12/14/25. Consultant Pharmacist EE stated she completed the MRRs and GDRs for the facility and sent them in emails. She stated she never received a response to any of her emails from the facility. She stated she had never been to the facility for an onsite visit. On 01/13/26 at 03:31 PM, Administrative Staff A stated she found a pharmacy review book that had pharmacy reviews in them, but they were blank. She stated she would continue to look for the completed pharmacy reviews. On 01/14/26 at 12:18 PM, Consultant Nurse C stated she was unable to find any GDRs or rationales. On 01/14/26 at 05:45 PM, Consultant Nurse C stated the director of nursing (DON) was responsible for pharmacy reviews after the pharmacy representative completed the review and put their recommendations in the monthly report. She stated she expected the DON to open the reviews, and the administrator should be reviewing them too. Consultant Nurse C stated the DON took the pharmacy reviews, completed the nursing recommendations, and sent the other recommendations to the physician. She stated the facility was unable to locate any pharmacy reviews with physician response outside of the ones scanned into the EMR. The facility's Medication Regiment Review Policy last revised 06/26/24, directed the pharmacist documented electronically that each medication regimen review had been completed. The pharmacist either documented that no irregularity was identified or the nature of the identified irregularities. The pharmacist communicated any irregularities to the facility in written communication to the attending physician, the facility's medical director, and the DON. The policy directed written communications from the pharmacist became a permanent part of the resident's medical record. Facility staff acted upon all recommendations according to procedures for addressing medication regimen review irregularities. - R3's electronic medical record (EMR) documented diagnoses of hypertensive heart disease without heart failure (involves the heart muscle thickening and stiffening (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due to long-term high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), 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), epilepsy (brain disorder characterized by repeated seizures), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and schizoaffective disorder bipolar type (mental health condition marked by a mix of psychotic symptoms like hallucinations and delusions with mood swings). The Quarterly Minimum Data Set (MDS), dated [DATE], recorded R3 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R3 had upper extremity impairment to one side, and lower extremity impairment to both sides. The MDS documented R3 used a wheelchair. The MDS documented R3 required substantial to maximal assistance for chair, bed, toilet and shower transfers. The MDS documented R3 required substantial to maximal assistance for transitioning from seated to a standing position. The MDS documented R3 was dependent on staff for toileting hygiene, bathing, lower body dressing, and personal hygiene. The Psychotropic Drug Use Care Area Assessment (CAA) dated 09/05/25, documented R3 was taking antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressant (class of medications used to treat mood disorders), antianxiety (class of medications that calm and relax people) and sedative hypnotic (class of medications used to induce calm or sleep) medications. The CAA documented R3 had no adverse effects during the look back period. R3's 10/14/21 Care Plan documented R3 was at risk for adverse side effects to medications with black box warnings (BBW): Warfarin (medication used to prevent and treat blood clots), Metoprolol (medication used to treat high blood pressure), quetiapine (antipsychotic medication), Diclofenac (medication used to treat pain and inflammation), Levothyroxine (medication used to treat underactive thyroid), Ozempic (used to treat diabetes), Furosemide (medication used to treat fluid retention and swelling), Escitalopram (antidepressant), divalproex (medication used to treat epilepsy and stabilize mood), clonazepam (medication used to treat panic disorder), and Nuplazid (antipsychotic medication). The Care Plan documented the following interventions: 03/28/22 - R3 took medications with a black box warning. These may be serious and life threatening. See Medication Administration Record (MAR) for specific adverse reactions.12/22/24 - Staff would know a GDR was contraindicated 10/11/24. 03/28/22 - Pharmacy will review R3's medications regularly and make recommendations as needed. R3's 08/24/24 Care Plan documented R3 used psychotropic medications: quetiapine (antipsychotic medication) related to Schizoaffective Disorder, Nuplazid (antipsychotic medication) related to Parkinson's psychosis (a non-motor symptom of Parkinson's disease that causes patients to experience hallucinations and, or delusions.), and Clonazepam for anxiety.08/24/24 - Consult with pharmacy, and Doctor of Medicine (MD) to consider dosage reduction when clinically appropriate at least quarterly.08/24/24 - Discuss with MD, and family related to ongoing need for use of medication. Review behaviors, interventions, alternate therapies attempted and their effectiveness as per facility policy.12/22/24 - Staff would know a GDR was contraindicated on 10/11/24. The Care Plan lacked further information related to the contraindicated GDR on 10/11/24. Review of R3's Pharmacy Review Notes from May 2025 to January 2026 revealed the following CP notes with a report referenced: 05/15/25 Note Text: MRR - See report. 12/13/25 Note Text: MRR - See report. 01/13/26 Note Text: MRR - See report. R3's EMR lacked evidence of a physician response to the MRR for May 2025, December 2025 and January 2026. Upon request, the facility was unable to provide the MRR or physician response to MRR for May 2025, December 2025 and January 2026. On 01/13/26 at 03:27 PM R3 sat in his wheelchair in his room. On 01/06/25 at 03:55 PM Consultant Pharmacist EE stated she took over as the consultant pharmacist in November 2025. She stated she emailed the facility on 11/14/25 to inform them of the change and to (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	setup a date for an onsite visit. Consultant Pharmacist EE stated she had emailed the facility again on 11/23/25 and 12/14/25. Consultant Pharmacist EE stated she had completed the MRRs and GDRs for the facility and sent them in her emails. Consultant Pharmacist EE stated she had never received a single response to any of her emails, from anyone in the facility. Consultant Pharmacist EE stated she had never been to the facility for an onsite visit. On 01/13/26 at 03:31 PM, Administrative Staff A stated she found a pharmacy review book that had pharmacy reviews in them, but they were blank. She stated she would continue to look for the completed pharmacy reviews. On 01/14/26 at 12:18 PM, Consultant Nurse C stated she was unable to find any GDRs or pharmacy reviews requested. On 01/14/26 at 05:45 PM Consultant Nurse C stated the Director of Nursing (DON) was responsible for the pharmacy reviews received from the consultant pharmacist. Consultant Nurse C stated the consultant pharmacist reviews mediations, parameters, indications or diagnosis that needs changed. Consultant Nurse C stated after the review the pharmacist will put a recommendation in a report and sends them to the facility. Consultant Nurse C stated the emails are sent monthly and are encrypted. Consultant Nurse C further stated the DON was responsible for opening them; however, she stated the facility administrator should have opened them as well. Consultant Nurse C stated some recommendations have specific requests for the physician. Consultant Nurse C stated she would prefer the DON and Assistant Director of Nursing (ADON) to take care of the pharmacy recommendations. Consultant Nurse C stated she thought the pharmacy recommendations were uploaded in the resident's EMR. Consultant Nurse C stated she was unable to find any pharmacy recommendations with a physician response or physician signature. The facility's Medication Regimen Review Policy with a revised date of 06/26/24, documented the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. Collaboration with other members of the interdisciplinary team, including the resident, their family, and or resident representative. The pharmacist shall document electronically that each medication regime review has been completed. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities. The facility staff shall act upon all recommendations according to procedure for addressing medication regime review irregularities. - R24's electronic medical record (EMR) documented diagnoses of mild cognitive impairment, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), essential primary hypertension (high blood pressure that is not the result of a medical condition), need for assistance with personal care, and difficulty in walking. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded R24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R24 required supervision or touch assistance for Activities of Daily Living (ADLs). The Psychotropic Drug Use Care Area Assessment (CAA) dated 10/23/25, documented R24 was receiving psychotropic (alters mood or thought) medications, antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressant (class of medications used to treat mood disorders), antianxiety (class of medications that calm and relax people). Psychotropic medications may increase the risk of falls, sedation, weight gain, confusion, and adverse drug interactions. They may also impact mood, cognition, sleep, and functional abilities. R24's 10/27/25 Care Plan documented R4 had a guardian to assist in decision making due to anxiety, Post-Traumatic Stress Disorder (PTSD - mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), mild cognitive impairment, and the resident was unable to make decisions on her own. The Care Plan documented the following interventions:10/27/25 - Staff would ensure the resident's guardian's wishes were followed.10/27/25 - Staff would provide opportunities for the resident to make simple choices with ADL care. R24's 10/27/25 Care Plan documented R24 had a mood problem related to anxiety. The Care Plan documented the following interventions:10/27/25 - Staff would administer medications as (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered and monitor/document for side effects and effectiveness.10/27/25 - Behavioral health consults as needed.10/27/25 - Monitor and record mood to determine if problems seem to be related to external causes, such as medications, treatments, or concern over diagnosis. Review of R24's Pharmacy Review Notes from October 2025 to January 2026 revealed the following CP notes: 11/23/25 Note Text: MRR - See report.12/14/25 Note Text: MRR - See report.01/14/26 Note Text: MRR - no recommendations.R24's EMR lacked evidence of a physician response to the MRR for November 2025, and December 2025. Upon request, the facility was unable to provide the MRR or physician response to MRR for November 2025, and December 2025. On 01/12/26 at 03:45 PM R24 sat on her bed in her room. On 01/06/25 at 03:55 PM Consultant Pharmacist EE stated she took over as the consultant pharmacist in November 2025. She stated she emailed the facility on 11/14/25 to inform them of the change and to setup a date for an onsite visit. Consultant Pharmacist EE stated she had emailed the facility again on 11/23/25 and 12/14/25. Consultant Pharmacist EE stated she had completed the MRRs and GDRs for the facility and sent them in her emails. Consultant Pharmacist EE stated she had never received a single response to any of her emails, from anyone in the facility. Consultant Pharmacist EE stated she had never been to the facility for an onsite visit. On 01/13/26 at 03:31 PM, Administrative Staff A stated she found a pharmacy review book that had pharmacy reviews in them, but they were blank. She stated she would continue to look for the completed pharmacy reviews. On 01/14/26 at 12:18 PM, Consultant Nurse C stated she was unable to find any GDRs or pharmacy reviews requested. On 01/14/26 at 05:45 PM Consultant Nurse C stated the Director of Nursing (DON) was responsible for the pharmacy reviews received from the consultant pharmacist. Consultant Nurse C stated the consultant pharmacist reviews mediations, parameters, indications or diagnosis that needed changed. Consultant Nurse C stated after the review the pharmacist would put a recommendation in a report and sends them to the facility. Consultant Nurse C stated the emails were sent monthly and were encrypted. Consultant Nurse C further stated the DON was responsible for opening them; however, she stated the facility administrator should have opened them as well. Consultant Nurse C stated some recommendations have specific requests for the physician. Consultant Nurse C stated she would prefer the DON and Assistant Director of Nursing (ADON) to take care of the pharmacy recommendations. Consultant Nurse C stated she thought the pharmacy recommendations were uploaded in the resident's EMR. Consultant Nurse C stated she was unable to find any pharmacy recommendations with a physician response or physician signature. The facility's Medication Regimen Review Policy with a revised date of 06/26/24, documented the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. Collaboration with other members of the interdisciplinary team, including the resident, their family, and or resident representative. The pharmacist shall document electronically that each medication regime review has been completed. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities. The facility staff shall act upon all recommendations according to procedure for addressing medication regime review irregularities.

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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 reported a census of 34 residents. Based on observation, interview, and record review the facility failed to store schedule II-V controlled narcotic medications in manner in which only authorized staff had access and failed to ensure the quantity stored was minimal in order to identify potential drug diversion and/or missing doses, to include narcotic medications awaiting destruction. The facility had one locked cabinet inside the medication room, which was used for narcotic medications awaiting destruction. The administrator and facility staff did not know who had the key for the locked narcotic destruction cabinet and required maintenance staff to cut the lock off of the cabinet on [DATE], revealing the cabinet was full of narcotic controlled medications which had not been destroyed since at least February 2025. The facility audit revealed at least 55 narcotic medication prescriptions (of an unknown quantity for each) in which the facility could not account for. Findings included:- An onsite observation on [DATE] revealed the facility had one medication room with one narcotic destruction box, which was locked. Inquiry revealed direct care and licensed nursing staff did not know who had the key to the narcotic destruction box, but most assumed Administrative Nurse B had the key. During an interview with Administrative Nurse B on [DATE] at 11:02 AM revealed she was supposed to have the key to the narcotic destruction cabinet, but she needed to look in her desk. Administrative Nurse B said she did not know what happened to the narcotic destruction box key and said she knew some medications were in there, but she was not sure what medications they were. Administrative Nurse B then said that's why I asked maintenance to cut off the lock. I don't know what is in there and said she asked maintenance to cut of the lock (indicated prior to [DATE]). During an interview on [DATE] at 01:47 PM, Maintenance Staff J stated the (narcotic destruction) key was not something he messed with, and he assumed the nurses or Administrative Nurse B had it. Maintenance Staff J said he did not track the key and then stated no one ever asked him to cut the lock off of the narcotic destruction cabinet or had informed him the key was lost. Maintenance Staff J said he did not know there was an issue with the narcotic destruction box. During an interview on [DATE] PM at 12:06 PM, Administrative Staff A stated Administrative Nurse B should have the narcotic destruction key. Administrative Staff A stated she had not asked Administrative Nurse B if she had key, but she should have it and thought she did. During an interview on [DATE] at 02:27 PM Administrative Staff A stated she was not sure about the key and no one she talked to knew where it was or knew who had it. During an interview on [DATE] at 03:27 PM Administrative Staff A stated they were going to cut the lock off and place a new lock to the narcotic destruction box and record new sheets of what was in the cabinet. During an interview on [DATE] at 04:25 PM Administrative Staff A stated the facility would cut the lock off of the cabinet to see what was inside, place a new lock, and she would keep the key. She said it was not done yet, but it would be. During an interview with Licensed Nurse T on [DATE] at 10:18 AM revealed discontinued medications to destroy went into the cabinet with the lock and stated the nurses did not get in the cabinet. LN T said she thought Administrative Nurse B had the key to that cabinet. During an interview on [DATE] at 10:19 AM, Licensed Nurse S stated discontinued medications to destroy were put in the cabinet in the medication room, which has a slot on the cabinet door and a lock on it. She said the staff slide the medication card with the count sheet into the cabinet. LN S said no one had access to unlock the cabinet, aside from Administrative Nurse B. LN S said Administrative Nurse B can access the box/cabinet. During an interview on [DATE] at 07:40 PM LN S said she talked to Administrative Nurse B about the narcotic destruction key and Administrative Nurse B told her she did not know who had it. LN S said Administrative Nurse B told her some things may be missing from the cabinet because another nurse may have accessed it. LN S said the former employee Administrative Nurse B mentioned would not have had that key, since that (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person was medical records. During an observation in the medication room on [DATE] at 05:30 PM, Maintenance Staff J cut the lock of the medication destruction cabinet in the presence of Administrative Staff A and LN S and replaced the lock with a new one. Inside the medication destruction cabinet were stacks of medication cards with count sheets attached to them, one dated back to 2024. Review of the facility provided Medication Storage and Destruction policy revealed the purpose of the policy was to ensure the safe, secure, and compliant storage and destruction of medications, including controlled substances, in accordance with Kansas Administrative Regulations, pharmacy standards, and federal requirements for nursing facilities. The policy included the following information regarding controlled substances and keys or access codes: access was limited to authorized licensed nurses, keys or access codes to controlled substances shall not be shared or left unattended and shall be controlled and tracked by facility leadership. The policy included a section on discontinued, expired, or unused medications noting controlled substances awaiting destruction must be placed in the locked narcotic destruction box. The section on Narcotic Destruction Box read the facility shall maintain a locked narcotic destruction box in a secure location and access to the box was limited to the pharmacist and unauthorized licensed nursing staff as designated by the facility. Keys or access controls shall be accounted for at all times, logged if applicable, changed immediately if compromised, and noted the destruction box should never be left unlocked or unsecured.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. The census totaled 34 with 14 in the sample. Based on interview, and record review the facility failed to provide evidence they offered Covid-19 (highly contagious respiratory virus) immunizations to residents who resided at the facility. The facility further failed to provide signed consents/declinations and/or evidence of vaccination administration related the Covid-19 vaccine for Residents (R) 2, R6, R7, R11, and R16. Findings included- Upon request on 01/14/26 at 10:32 AM, the facility was unable to provide Covid-19 vaccination signed consents, declinations, or documentation of vaccination administrations for influenza, pneumococcal, and/or Covid-19 vaccinations for R2, R6, R7, R11, and R16. On 01/14/26 at 12:13 PM, Consultant Nurse C stated she was unable to find requested immunization documentation. During an interview with Consultant Nurse C at 05:45 PM on 01/14/26 she reported the facility Director of Nursing or Social Services would complete the immunization consent/declinations. She stated it was the responsibility of Administrative Nursing Staff B to oversee the immunizations and ensure they were administered. Once resident consent for the immunizations was obtained, she expected staff to administer the immunization and for staff to document the immunization administration in the Electronic Health Record. Review of the COVID-19 Vaccine - Educate and Offer policy dated 06/26/24 revealed the facility would make the Covid-19 vaccine available to all residents and staff and would educate residents and staff about the vaccine.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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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 identified a census of 34 residents. The sample included 14 residents, with three residents reviewed for beneficiary notification. Based on record review and interviews, the facility failed to provide Form CMS 10055- Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) to Resident (R) 29 and R42. Findings included:- Upon request of the Medicare Liability Notice, CMS 101123- Notice of Medicare Non-Coverage (NOMNC) and SNF ABN for R29, the facility provided a NOMNC, but no ABN for R29. The NOMNC documented R29's physical therapy services ended on 07/29/25 due to R29 meeting their goals. R29 signed the NOMNC on 07/25/25. The facility filled out the SNF Beneficiary Notification Review form and indicated the facility initiated the discharge from Medicare Part A services with the resident having remaining benefit days. The form documented a SNF ABN was not provided as the facility was unaware the form needed to be completed. Upon request of the NOMNC and ABN for R42, the facility provided a NOMNC, but no ABN for R42. The NOMNC documented R42's Med A therapy services ended on 08/20/25 due to R42 reaching his maximum functional level at that time. R42 signed the NOMNC on 08/15/25. The facility filled out the SNF Beneficiary Notification Review form and indicated the facility initiated the discharge from Medicare Part A services with the resident having remaining benefit days. The form documented a SNF ABN was not provided as the facility was unaware the form needed to be completed. On 01/14/26 at 03:25 PM, Social Services F stated she had been the Social Services Designee (SSD) since November 2025. She stated she received notification from nursing or therapy of a resident's discharge from skilled services, and she filled out the NOMNC or both depending on the situation. She stated the facility had a policy she referenced to know if she needed to issue an ABN. On 01/14/26 at 03:34 PM, Business Office Manager (BOM) L stated she was the SSD prior to SSD F. She stated therapy sent her notices of when a resident was discharging from skilled services. BOM L stated she gave both a NOMNC and ABN to the resident because the ABN let the resident know they could pay for services themselves if they wanted. She stated if the ABN was not with the NOMNC for R29 and R42 then she did not do them. Review of the SNF ABN Instructions revealed the SNF ABN provided information to the patient so he/she could decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 14 residents with seven residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to ensure the physician documented a rationale with risk versus benefit and nonpharmacological attempts prior to the use of antipsychotic (a class of medications used to treat psychosis and other mental emotional conditions) medications for R1, the facility failed to ensure a 14-day stop date for an as needed (PRN) psychotropic (alters mood or thought) medication for R32, and the facility failed to attempt a gradual dose reduction (GDR) or provide a rationale against a GDR for psychotropic medications for R1, R32, and R3. Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The admission Minimum Data Set (MDS) dated 03/17/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 had no behaviors. R1 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), and anticonvulsant (a class of medications used to treat seizures) medications. R1 received antipsychotic medications on a routine basis only and a gradual dose reduction (GDR) had not been attempted. The Quarterly MDS dated 12/02/25 documented R1 had a BIMS score of nine, which indicated moderate cognitive impairment. R1 had no behaviors. R1 received antipsychotic, antianxiety (a class of medications that calm and relax people), antidepressant, diuretic (a class of medication to promote the formation and excretion of urine), and hypoglycemic (a class of medications used to lower blood sugar levels). R1 received antipsychotic medications on a routine basis only and a gradual dose reduction had not been attempted. The Psychotropic Drug Use Care Area Assessment (CAA) dated 03/29/25, lacked an analysis of findings. R1's 08/11/25 Care Plan last revised 12/09/25, documented R1 receive medication for bipolar disorder. The Care Plan documented the following interventions:08/12/25- Staff administered antidepressant medications as ordered by physician and monitored/documented side effects and effectiveness every shift.08/12/25- Staff monitored/documented/reported as needed (PRN) adverse reactions to antidepressant therapy. R1's 8/11/25 Care Plan last revised 08/12/25, documented R1 used lorazepam (antianxiety medication) to decrease anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Care Plan documented the following interventions:08/12/25- Staff administered antianxiety medications as ordered by physician and monitored for side effects and effectiveness every shift.08/12/25- Staff monitored/documented/reported PRN any adverse reactions to antianxiety therapy.08/12/25- Staff monitored/recorded occurrences of target behavior symptoms and documented per facility protocol. R1's 08/11/25 Care Plan last revised 12/09/25, documented R1 took antipsychotic medications. The Care Plan documented the following interventions: 08/12/25- Staff administered psychotropic medications as ordered by physician and monitored for side effects and effectiveness every shift.08/12/25- Staff consulted with pharmacy and the medical doctor to consider dosage reduction when clinically appropriate at least quarterly.08/12/25- Staff discussed with the medical doctor and family the ongoing need of medication. Staff reviewed behaviors/interventions, alternative therapies attempted, and their effectiveness per facility policy. R1's EMR revealed the following orders: An order with a start date of 04/08/25, for olanzapine (antipsychotic medication) five milligrams (mg) at bedtime for bipolar disorder. An order with a start date of 05/01/25, for quetiapine fumarate (antipsychotic medication) 150 mg twice a day for bipolar disorder. An order with a start date of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/05/25, for lorazepam (antianxiety medication) 0.5 mg three times a day for anxiety disorder. An order with a start date of 08/18/25, for Remeron (antidepressant medication) 15 mg at bedtime for depression. Upon request, the facility was unable to provide a physician documented risk versus benefit statement with nonpharmacological attempts prior to olanzapine and quetiapine use. Upon request, the facility was unable to provide GDR attempts or a rationale against a GDR for olanzapine, quetiapine, lorazepam, and Remeron medications. On 01/13/25 at 01:53 PM, R1 sat in her wheelchair in her room. She appeared to be upset and talking to herself. On 01/14/26 at 12:18 PM, Consultant Nurse C stated she was unable to find any GDRs or rationales. On 01/14/26 at 05:45 PM, Consultant Nurse C stated the facility attempted GDRs depending on the medication and provided a rationale if they did not complete a GDR. She stated the physician should do a risk versus benefit statement and nonpharmacological attempt documentation prior to starting antipsychotic medications. The facility's Unnecessary Drugs without Adequate Indication for Use Policy last revised 05/18/24, directed the facility documented indications for initiating, withdrawing, or withholding medications as well as the non-pharmacological approaches as determined by assessing the resident's underlying condition, current status, symptoms, expressions, preferences, and goals for treatment including identification of underlying causes. The policy directed the facility provided documentation in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed. The facility's Use of Psychotropic Medication Policy last revised 06/26/24, directed the facility educated residents and/or their representatives on the risks and benefits of psychotropic drug use, as well as alternative treatments and non-pharmacological interventions. The policy directed residents who used psychotropic drugs received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the drugs. - R32 admitted to the facility on [DATE]. R32's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI-an injury to the brain caused by external forces) with loss of consciousness, adult failure to thrive, other seizure (violent involuntary series of contractions of a group of muscles), major depressive disorder (major mood disorder), and generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R32's admission Minimum Data Set (MDS) dated 08/24/25, documented R32 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. R1 had no falls since admission. R32 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and anticonvulsant (a class of medications used to treat seizures) medications. R32 received antipsychotic medications on a routine basis only and a gradual dose reduction (GDR) had not been attempted. R32's Quarterly MDS dated 11/04/25, documented a BIMS was not conducted due to R32 being rarely/never understood. R32 received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. R32 received antipsychotic medications on a routine basis only and a GDR had not been attempted. The Psychotropic Use Care Area Assessment (CAA) dated 08/24/25, documented R32 had no adverse effects during the lookback period. R32's 10/31/25 Care Plan last revised 11/20/25, documented R32 used antianxiety medications related to anxiety disorder. The Care Plan documented the following interventions:11/19/25- Staff administered antianxiety medications as ordered by physician and monitored for side effects and effectiveness every shift.11/19/25- Staff monitored/recorded occurrence for the target behavior symptoms. R32's 11/19/25 Care Plan documented R32 used psychotropic medications. The Care Plan documented the following interventions:11/19/25- Staff administered psychotropic medications as ordered by physician and monitored for side effects and effectiveness every shift.11/19/25- Staff consulted with pharmacy and the medical doctor to consider a dosage reduction when clinically appropriate at least quarterly.11/19/25- Staff discussed with medical doctor and family the ongoing need for the use of medication. Staff reviewed behaviors/interventions, alternate therapies attempted, and their effectiveness as per facility (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy.11/20/25- Staff attempted medication adjustments, monitored R32, and notified the physician of any effects. R32's 11/19/25 Care Plan documented R32 used antidepressant medications. The Care Plan documented the following interventions:11/19/25- Staff administered antidepressant medications as ordered by physician and monitored/documented side effects and effectiveness every shift.11/19/25- Staff monitored/documented, reported as needed (PRN) any adverse reactions to antidepressant therapy. R32's EMR revealed the following orders: An order with a start date of 08/19/25, for quetiapine fumarate (antipsychotic medication) 100 milligrams (mg) at bedtime for anxiety disorder. An order with a start date of 10/17/25, for lorazepam 2 mg/milliliters (mL) give 0.5 mL every four hours as needed for anxiety/agitation. The order did not have a 14-day stop date. An order with a start date of 10/29/25, for lorazepam 0.5 mg two times a day related to anxiety disorder. An order with a start date of 11/21/25, for duloxetine hydrochloride 60 mg one time a day for anxiety. An order with a start date of 11/24/25, for quetiapine fumarate 50 mg in the morning for diffuse TBI and anxiety disorder. An order with a start date of 12/19/25, for trazodone 25 mg at bedtime for sleep. Upon request, the facility was unable to provide GDR attempts or a rationale against a GDR for olanzapine, quetiapine, lorazepam, and Remeron medications. Upon request, the facility was unable to provide physician documentation on extended duration usage past 14-days for PRN lorazepam. On 01/14/26 at 10:33 AM, R32 self-propelled in his wheelchair down the hallway towards his room. An unidentified female staff member stated to another staff member that R32 wanted to lay down for a bit. On 01/14/26 at 12:18 PM, Consultant Nurse C stated she was unable to find any GDRs or rationales. On 01/14/26 at 05:45 PM, Consultant Nurse C stated the facility attempted GDRs depending on the medication and provided a rationale if they did not complete a GDR. She stated PRN psychotropics had a 14-day stop date and if they were needed longer, then the physician put a rationale in on why it continued past the 14-days. The facility's Unnecessary Drugs without Adequate Indication for Use Policy last revised 05/18/24, directed the facility documented indications for initiating, withdrawing, or withholding medications as well as the non-pharmacological approaches as determined by assessing the resident's underlying condition, current status, symptoms, expressions, preferences, and goals for treatment including identification of underlying causes. The policy directed the facility provided documentation in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed. The facility's Use of Psychotropic Medication Policy last revised 06/26/24, directed the facility educated residents and/or their representatives on the risks and benefits of psychotropic drug use, as well as alternative treatments and non-pharmacological interventions. The policy directed residents who used psychotropic drugs received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the drugs. The policy directed the facility used PRN orders for psychotropic drugs only when the medication was necessary to treat a specific diagnosed condition documented in the clinical record and for a limited time, example 14 days. If the physician believed it appropriate for the order to be extended beyond 14 days, the provider documented their rationale in the resident's medical record and indicated the duration for the PRN order. - R3's electronic medical record (EMR) documented diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), 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), epilepsy (brain disorder characterized by repeated seizures), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and schizoaffective disorder bipolar type (mental health condition marked by a mix of psychotic symptoms like hallucinations and delusions with mood swings). The Psychotropic Drug Use Care Area Assessment (CAA) dated 09/05/25, documented R3 required antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressant (class of medications used to treat mood disorders), antianxiety (class of medications that calm and relax people) and sedative hypnotic (class of medications used to induce (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calm or sleep) medications. The CAA documented R3 had no adverse effects to the medications during the look back period. R3's 10/14/21 Care Plan revealed the following interventions: 03/28/22 - The pharmacy would review R3's medications regularly and make recommendations as needed.03/28/22 - R3 took medications with Black Box Warnings (most serious warnings issued by the Food and Drug Administration). Staff would know the warnings may be serious and life threatening and the intervention instructed staff to see the resident's Medication Administration Record (MAR) for specific adverse reactions.08/24/24 - Staff would know R3 used psychotropic medications: quetiapine (antipsychotic medication) related to Schizoaffective Disorder, Nuplazid (antipsychotic medication) related to Parkinson's psychosis (a non-motor symptom of Parkinson's disease that causes patients to experience hallucinations and, or delusions.), and Clonazepam (benzodiazepine, class of medication used to calm the nervous system) for anxiety.08/24/24 - Discuss with MD, and family related to ongoing need for use of medication. Review behaviors, interventions, alternate therapies attempted and their effectiveness as per facility policy.08/24/24 - The facility would consult with pharmacy, and Doctor (MD) to consider dosage reduction when clinically appropriate at least quarterly.12/22/24 - Staff would know a GDR was contraindicated 10/11/24. The Care Plan lacked further information related to the contraindicated GDR on 10/11/24. Review of the resident's Physician Orders revealed the following: A Physicians Order with a start date of 01/20/25 and an end date of 11/18/25, documented Quetiapine Fumarate 100mg. Give 1 tablet by mouth three times a day for schizoaffective disorder. A Physicians Order with a start date of 11/18/25, documented Quetiapine Fumarate100mg. Give 1 tablet by mouth three times a day for schizoaffective disorder. R3's EMR lacked evidence a GDR was completed for R3's Quetiapine Fumarate order. A Physicians Order with a start date of 04/30/24, documented Clonazepam tablet 0.5 milligrams (MG) tablet two times a day for anxiety. A Pharmacy Review Note dated 06/13/25, documented a medication regimen review (MRR) for R3 was performed. The note documented R3 received the following psychotropic medications that were due for review: Clonazepam 0.5 milligrams (mg) twice a day and Depakote 1500 mg at bedtime. The note documented the Centers for Medicare and Medicaid Services (CMS) guidelines required psychotropic medications to be evaluated for a gradual dose reduction and/or discontinuation twice in the first year, at minimum, then at prescriber's discretion thereafter. The note recommended R3's Depakote be decreased to 1000 mg at bedtime. R3's EMR lacked evidence of a physician's response for the GDR request on 06/13/25. The facility was unable to provide evidence of a physician's response or risk versus benefit evaluation upon request. On 01/13/26 at 03:27 PM R3 sat in his wheelchair in his room. On 01/06/25 at 03:55 PM Consultant Pharmacist EE stated she took over as the consultant pharmacist in November 2025. She stated she emailed the facility on 11/14/25 to inform them of the change and to setup a date for an onsite visit. Consultant Pharmacist EE stated she emailed the facility again on 11/23/25 and 12/14/25. Consultant Pharmacist EE stated she completed the MRRs and GDRs for the facility and sent them in her emails. Consultant Pharmacist EE stated she never received a single response to any of her emails from anyone in the facility. Consultant Pharmacist EE stated she had never been to the facility for an onsite visit. On 01/13/26 at 03:31 PM, Administrative Staff A stated she found a pharmacy review book that had pharmacy reviews in them, but they were blank. She stated she would continue to look for the completed pharmacy reviews. On 01/14/26 at 12:18 PM, Consultant Nurse C stated she was unable to find any GDRs or pharmacy reviews requested. On 01/14/26 at 05:45 PM Consultant Nurse C stated the Director of Nursing (DON) was responsible for the pharmacy reviews received from the consultant pharmacist. Consultant Nurse C stated the consultant pharmacist reviewed mediations, parameters, indications and/or diagnoses that needed changed. Consultant Nurse C stated after the review the pharmacist would put a recommendation in a report and send them to the facility. She stated the emails were sent monthly and were encrypted. Consultant Nurse C further stated the DON was responsible for opening them; however, she stated the facility administrator should have opened them as well. Consultant Nurse C stated the GDR process was for (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trying to lower the dose of antipsychotic medications and went to the physician. She stated if the physician agreed they made changes, if they disagreed with the recommendations the physician would put in a rationale. She stated from there the GDR went back to the nurse to make any ordered changes. Consultant Nurse C stated GDR attempts depended on the medication; however, they should at least be attempted, or if not, then a rationale was needed. She stated physicians should do the risk versus benefit statement and documentation for nonpharmacologic interventions attempted. Consultant Nurse C stated she would prefer the DON and Assistant Director of Nursing (ADON) to take care of the pharmacy recommendations. Consultant Nurse C stated she thought the pharmacy recommendations were uploaded in the resident's EMR. Consultant Nurse C stated she was unable to find any pharmacy recommendations, or GDRs, with a physician response or physician signature. The facility's Unnecessary Drugs without Adequate Indication for Use Policy last revised 05/18/24, directed the facility documented indications for initiating, withdrawing, or withholding medications as well as the non-pharmacological approaches as determined by assessing the resident's underlying condition, current status, symptoms, expressions, preferences, and goals for treatment including identification of underlying causes. The policy directed the facility provided documentation in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed. The facility's Use of Psychotropic Medication Policy last revised 06/26/24, directed the facility educated residents and/or their representatives on the risks and benefits of psychotropic drug use, as well as alternative treatments and non-pharmacological interventions. The policy directed residents who used psychotropic drugs received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the drugs. The policy directed the facility used PRN orders for psychotropic drugs only when the medication was necessary to treat a specific diagnosed condition documented in the clinical record and for a limited time, example 14 days. If the physician believed it appropriate for the order to be extended beyond 14 days, the provider documented their rationale in the resident's medical record and indicated the duration for the PRN order.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. The facility identified a census of 34 residents. The sample included 14 residents. Based on record review and interviews, the facility failed to complete the Care Area Assessment (CAA) analysis of findings, related to a Comprehensive Minimum Data Set (MDS), for Resident (R) 1, R16, and R32, in order to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. Findings included:- R1's admission MDS dated 03/17/25, triggered CAAs for cognitive loss/dementia, urinary incontinence/indwelling catheter, and psychotropic drug use. The triggered CAAs lacked completion with analysis of findings. R16's admission MDS dated 07/09/25, triggered CAAs for cognitive loss/dementia and activities of daily living (ADL) functional/rehabilitation potential. The triggered CAAs lacked completion with analysis of findings. R32's admission MDS dated 08/24/25, triggered CAAs for cognitive loss/dementia and behavioral symptoms. The triggered CAAs lacked completion with analysis of findings. On 01/20/26 at 01:01 PM, Consultant Nurse Q stated as the regional MDS Coordinator, she completed the MDS for the facilities. She stated if the comprehensive MDS triggered CAAs, she looked to see what assistance the resident needed and made sure to update the care plan. Consultant Nurse Q stated she did not complete the analysis of findings for the CAAs because she was always told she did not have to. The facility's MDS 3.0, Care Assessment Summary and Individualized Care Plans policy, last revised 11/06/23, directed the interdisciplinary team completed the CAAs and the most important aspect in the section is the MDS did not constitute a comprehensive assessment without the CAA summary being completed. The CAA summary drove the development of the individualized care plan, and the care area trigger alerted the assessor that interventions needed placed to address the care concerns in the plan of care for the individual plan of care for the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to develop and implement a comprehensive, individualized care plan to address Resident (R) 1's dementia diagnosis with behaviors, triggers, and interventions; and failed to develop and implement a comprehensive, individualized care plan to address R16's activities of daily (ADL) status and required assistance with ADLs. Findings included: - R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The admission Minimum Data Set (MDS) dated 03/17/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 had no behaviors. R1 preferred reading books, newspapers, or magazines; listening to music; being around animals such as pets; doing things with groups of people; participating in her favorite activities; and spending time outdoors. The Quarterly MDS dated 12/02/25 documented R1 had a BIMS score of nine, which indicated moderate cognitive impairment. R1 had no behaviors. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/29/25 lacked an analysis of findings. R1's 03/29/25 Care Plan documented R1 had impaired cognitive function and impaired thought processes related to dementia. The Care Plan documented the following interventions: 03/29/25- Staff administered medications as ordered and monitored for side effects and effectiveness.03/29/25- Staff communicated with R1, her family, and caregivers regarding R1's capabilities and needs.03/29/25- Staff kept R1's routine consistent and tried to provide consistent caregivers as much as possible in order to decrease confusion.03/29/25- Staff monitored, documented, and reported as needed, any changes in cognitive function.03/29/25- Staff provided R1 with reassuring responses to allow R1 to feel safe.03/29/25- Staff used a calm, gentle approach, and explained to R1 about any problems or actions that took place. The care plan did not address individualized behaviors, triggers, and interventions for R1's dementia diagnosis and related behaviors. R1's 09/05/25 Care Plan documented R1 had the potential for a psychosocial well-being problem related to her bipolar disorder and dementia. The Care Plan documented the following interventions:09/05/25- Staff allowed R1 time to answer questions and to verbalize her feelings, perceptions, and fears.09/05/25- Staff consulted with social services and psychiatric services.09/05/25- Staff provided opportunities for R1 and her family to participate in her care.09/05/25- When conflict arose, staff moved R1 to a calm, safe environment and allowed her to vent or share her feelings. The care plan did not address individualized behaviors, triggers, and interventions for R1's dementia diagnosis and related behaviors. R1's EMR revealed the following: An Orders- Administration Note on 08/22/25 at 10:18 PM, documented R1 stated she was not checking her blood sugar until the [expletive] in the office gave her money. A Behavior Note on 08/23/25 at 01:18 PM, documented R1 refused vital signs and blood glucose check that shift. R1 let the staff check her oxygen saturation after the smoke break. R1 stated she was mad about her money. A Behavior Note on 10/20/25 at 10:56 AM, documented staff offered R1 a shower that shift and she refused. Staff educated R1 on the importance of routine hygiene for physical and mental well-being. R1 continued to refuse and continued yelling in her room. The nurse educated R1 to let nursing staff know if she changed her mind or wanted a shower on a different day. R1 refused to acknowledge education or the nurse who spoke to her. The nurse left R1's room as to not further escalate R1's yelling. A Behavior Note on 12/30/25 at 12:02 PM, documented R1 yelled out in the front room that she knew the facility had her money and to give her the money. The nurse explained to R1 that she had her own money on her debit card and no facility staff had access to it. R1 continued to yell out (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stated to watch her [expletive] them up, watch her [expletive] them all up. The nurse attempted to talk and redirect R1 without success. R1 continued to scream and cuss at staff in the front room. The nurse redirected R1 to her room for about three minutes, at which point, R1 self-propelled back out to the commons area, cussing but not yelling down the hallway. The nurse continued with redirection techniques. On 01/13/25 at 01:53 PM, R1 sat in her wheelchair in her room. She appeared to be upset and talking to herself. On 01/14/26 at 10:16 AM, R1 sat in her wheelchair in the day area. She had a coloring page and some colored pencils/markers in front of her in a closed package. R1 did not engage in the coloring activity. On 01/14/26 at 10:23 AM, R1 sat in her wheelchair in the day area. She appeared to be upset with an unidentified staff member. On 01/14/26 at 03:59 PM, Certified Nurse Aide (CNA) N stated dementia care varied by person and staff redirected residents with behaviors as much as they could. She stated she was not sure if the facility had any place that listed a resident's behaviors. She stated if a new aide came in, the facility did not have anything to tell them if a resident had behaviors. On 01/14/26 at 05:04 PM, Licensed Nurse (LN) S stated when a resident had behaviors, the staff documented to identify their behaviors and what redirections worked for them. She stated staff knew what behaviors a resident had through the progress notes and in the care plan. LN S stated the care plan should have individualized behaviors, triggers, and interventions. She stated the CNAs had access to the care plans and they received education on how to access them. LN S stated R1 had yelling behaviors, and she became aggressive with staff. She stated R1 had more behaviors when her family visited. On 01/14/26 at 05:45 PM, Consultant Nurse C stated she expected dementia care to be specialized to address the residents' different needs. She stated the care plans should list behaviors, triggers, and interventions for individual residents and staff knew the behaviors through the care plans. Consultant Nurse C stated resident care plans should be as individualized as possible to provide the best care. The facility's Dementia Care Policy last revised 06/26/24, directed the facility assessed, developed, and implemented care plans through an interdisciplinary team approach that include the resident, their family, and/or resident representative, to the extent possible. The policy directed the care plan interventions were related to each resident's individual symptomology and rate of dementia progression. The policy directed care, and services were person-centered and reflected each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. The policy directed the facility utilized individualized, non-pharmacological approaches to care to include meaningful activities aimed at enhancing the resident's well-being. The facility's Comprehensive Care Plans policy, last revised 10/31/24, directed the comprehensive care plan described resident specific interventions that reflected the resident's needs and preferences and aligned with the resident's cultural identity as indicated. - R16 admitted to the facility on [DATE]. R16's Electronic Medical Record (EMR) documented diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) and pain in the left hip. R16's admission Minimum Data Set (MDS) dated 07/09/25, documented R16 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. R16 had no impairment in her upper and lower extremities. R16 used a wheelchair, and she required staff supervision or touching assistance with standing and transfers. R16 had no falls since admission. R16's Quarterly MDS dated 01/05/26, documented R16 had a BIMS score of 14, which indicated intact cognition. R16 had no impairment in her upper and lower extremities. R16 used a walker and a wheelchair and required substantial to maximal staff assistance with standing and transfers. R16 had one noninjury fall since the last assessment. R16's Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/09/25, lacked an analysis of findings. R16's 10/04/25 Care Plan revised on 01/12/26, documented had an actual fall with unsteady gait. The Care Plan documented the following interventions:10/04/25- The staff continued R16's interventions on the at-risk plan.10/04/25- For no apparent acute injuries, the staff determined and addressed causative factors of R16's fall.10/04/25- The staff notified R16's legal guardian of any falls or updates to her fall (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk.10/04/25- The pharmacy consulted to evaluate R16's medications.10/04/25- Physical therapy consulted for strength and mobility for R16. R16's Care Plan did not address her ADL status including transfers and mobility. On 01/14/26 at 02:11 PM, R16 sat in a chair in the day area with her walker beside her. Activities Director E walked up and asked R16 if she wanted to go into the dining room for happy hour. Licensed Nurse (LN) S and Activities Director E got on either side of R16 and each placed one of their arms under her armpit and helped R16 stand up from the chair. R16 walked into the dining room with her walker. On 01/14/26 at 03:59 PM, Certified Nurse Aide (CNA) N stated she was unsure if there was a report sheet or Kardex (nursing tool that gives a brief overview of the care needs of each resident) on how to transfer a resident or to use a gait belt. She stated from shift-to-shift, they did rounds and will tell the oncoming staff any changes or new interventions. On 01/14/26 at 05:04 PM, LN S stated staff knew a resident's ADL status from the EMR. She stated the CNAs had access to the care plans and they received education on how to access them. She stated R16 used to transfer herself, but the chairs in the day area were so low that she needed someone to help her stand up. On 01/14/26 at 05:45 PM, Consultant Nurse C stated staff knew how to care for residents through their care plan and they should know how to access them. She stated care plans should be as individualized as possible to provide the best care, including ADLs and how a resident transferred. The facility's Comprehensive Care Plans policy, last revised 10/31/24, directed the comprehensive care plan described resident specific interventions that reflected the resident's needs and preferences and aligned with the resident's cultural identity as indicated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to review and revise Resident (R) 32's comprehensive care plan to include fall prevention interventions following multiple falls in the facility. Findings included:- R32 admitted to the facility on [DATE]. R32's Electronic Medical Record (EMR) documented diagnoses of diffuse traumatic brain injury (TBI-an injury to the brain caused by external forces) with loss of consciousness, adult failure to thrive, and other seizure (violent involuntary series of contractions of a group of muscles). R32's admission Minimum Data Set (MDS) dated 08/24/25, documented R32 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. R1 had no falls since admission. R32's Quarterly MDS dated 11/04/25, documented a BIMS was not conducted due to R32 being rarely/never understood. R32's Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA) dated 08/24/25, lacked an analysis of findings. R32's 09/19/25 Care Plan, revised on 01/12/26, documented R32 was at risk for falls and injury related to unsafe mobility and impaired safety awareness. R32 demonstrated difficulty with safe bed use and was often noncompliant with requesting assistance due to his cognitive impairment and poor decision-making related to his TBI. The presence of a standard bed frame increased R32's potential for injury if a fall occurred or R32 unsafely transferred from bed. R32 had a fall on 11/01/25 and 11/19/25. The Care Plan documented the following intervention:09/19/25- The staff provided a mattress on R32's floor for safety, comfort, and injury prevention. The care plan did not document interventions after R32's falls on 09/08/25 and 11/01/25. R32's EMR revealed the following: An Incident Note on 09/08/25 at 07:00 AM, documented the staff heard R32 yelling from the hallway. The staff noted R32 laid on his right side near the [NAME] exit door and he stated he fell trying to pull his pants up. The nurse performed a head-to-toe assessment, obtained R32's vital signs, and initiated neurological checks. R32 stated he did not hit his head, and the staff noted no injuries. An Incident Note on 09/08/25 at 08:02 AM, documented the nurse notified the director of nursing (DON), Consultant V, and Administrative Staff A, and attempted to notify R32's representative but her voicemail box was full. A Health Status Note on 09/14/25 at 03:17 PM, documented R32 experienced an unwitnessed fall today at 10:10 AM. The staff noted no injuries and R32 denied pain or hitting his head during the fall. R32 was chronically repetitive, disorganized, and became violent with staff members and other residents when agitated. R32 wandered the halls and appeared anxious. He knocked on doors and attempted to enter other resident's rooms, disturbing them, and frightening them. An Incident Note on 11/01/25 at 02:30 PM, documented the staff reported that R32 fell in the bathroom between two rooms and that his forehead was bleeding. The nurse noted a small, shallow abrasion to his left forehead that measured one centimeter (cm) by 1.5 cm. The nurse applied a clean dressing to R32's forehead and obtained his vital signs. R32 stated he needed to go to the bathroom, and he fell, hitting his forehead on the heater vent on the floor during the self-transfer. The staff assisted R32 into his wheelchair at 02:20 PM, just prior to the fall, in another resident's bathroom. The nurse notified Consultant V, Administrative Nurse B, and R32's representative. R32's neurological checks were within normal limits for him as he was only alerted to self only and had left sided paralysis. An Incident Note on 11/19/25 at 02:00 PM, documented the facility initiated one-on-one safety supervision with a staff member to maintain continuous visual contact to prevent further risk of harm to self or others at that time. Upon request for fall investigations for R32, the facility provided reports for R32's falls on 09/08/25 at 07:00 AM and 09/14/25 at 10:10 AM. The facility did not provide a report for R32's fall on 11/01/25. The facility's report for R32's fall on 09/08/25 at 07:00 AM, documented Licensed Nurse (LN) FF heard R32 yelling from the hallway. LN FF noted R32 laid on his right side near the [NAME] (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exit door. R32 stated he fell when he tried to pull his pants up. R32 stated he did not hit his head. The report lacked a root cause analysis of the fall. The facility's report for R32's fall on 09/14/25 at 10:10 AM, documented R32 experienced an unwitnessed fall in his bedroom. The report lacked a root cause analysis of the fall. On 01/13/26 at 01:52 PM, R32 self-propelled in his wheelchair down the hallway. An unidentified female staff member supervised him. On 01/14/26 at 10:33 AM, R32 self-propelled in his wheelchair down the hallway towards his room. An unidentified female staff member stated to another staff member that R32 wanted to lay down for a bit. On 01/14/26 at 03:59 PM, Certified Nurse Aide (CNA) N stated after a resident fell, the staff put an intervention into place if they were able to after a resident fell. She stated if new interventions went into place, she did not receive any notification of new interventions. CNA N stated the facility did not have a report sheet and she received updates through word of mouth. She stated, if there were interventions in the EMR, she did not know how to get on it to review. On 01/14/26 at 05:04 PM, LN S stated after a resident fell, she put an intervention in place at that time to prevent further falls then let the DON know about the intervention to update the care plan. She stated R32 fell once during an altercation and received a minor laceration. LN S stated he had fallen another time, but she did not know if the care plan had interventions put into place. She stated she expected there to be a fall intervention on the care plan after each fall. On 01/14/26 at 05:45 PM, Consultant Nurse C stated if a resident fell, she would like staff to do a root cause analysis if they had an idea of what caused the fall and put in an intervention immediately after the fall. She stated she expected every fall to have an intervention put into place and the charge nurses should be updating the care plan. Consultant Nurse C stated staff knew how to care for residents through their care plan and they should know how to access them. She stated care plans should be as individualized as possible to provide the best care. The facility's Fall Prevention Program policy, last revised 10/31/24, directed when a resident experienced a fall, the facility reviewed the resident's care plan and updated as indicated. The facility's Comprehensive Care Plans policy, last revised 10/31/24, directed interdisciplinary team reviewed and revised the comprehensive care plan with each comprehensive and quarterly MDS assessment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 34 with 14 sampled and one reviewed for catheter use and urinary tract infection. Based on observation, interview, and record review the facility failed to ensure Resident (R) 11 who entered the facility with a urinary catheter received the appropriate treatment and services to prevent urinary tract infections and other catheter associated concerns of wounds to both inner thighs without the use of an anchor for the catheter. The resident admitted to the hospital on multiple occasions, received intravenous antibiotics, and returned to the facility with no monitoring or intervention to prevent further infection or wound development. Findings included:- Review of the Centers for Medicare and Medicaid Services Form 802 also known as the Matrix for Providers provided by the facility on 01/11/26 to the survey team lacked evidence any residents required the use of an indwelling catheter. Question 11 instructs the facility to note residents with an indwelling catheter. Review of R11's Electronic Health Record (EHR) revealed the following diagnoses: methicillin resistant staphylococcus aureus infection (MRSA-a type of bacteria resistant to many antibiotics) diabetic chronic kidney disease, neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and chronic kidney disease. Review of the admission Minimum Data Set dated 08/19/25 revealed the resident had a brief interview for mental status score of 15, which indicated intact cognition. The resident required substantial/maximal assistance for activities of daily living including sitting to lying down, lying down to sitting, sitting to standing, chair to bed transfers, and toilet transfers. The resident required the use of an indwelling catheter and was frequently incontinent of bowels. Review of 08/19/25 Care Area Assessments (CAA) for R11 revealed the Functional Abilities (Self-Care and Mobility) CAA, Behavioral Symptoms CAA, Psychotropic Drug use CAA, Mood State CAA, and Psychosocial Well Being CAAs triggered for further review, but were not further assessed for potential problems to determine care planning decisions and implement effective interventions for his care. Review of the resident's Care Plan in the electronic health record (EHR) initiated on 08/15/25 revealed the following interventions:01/12/26 (4 days after the resident started antibiotics)- Staff would know the resident had a risk for infection of the urinary tract (UTI) and required antibiotics, which started 01/08/26 for seven days. Staff were to use contact precautions when caring for R11 due to MRSA infection. 12/17/25 - The resident would show no signs or symptoms of infection.12/17/25 - Staff were to administer antibiotic therapy as prescribed.12/17/25 - Staff would educate R11 and his representative on infection control practices.12/17/25 - Staff would alleviate the resident's pain.12/17/25 - Staff would initiate appropriate isolation precautions 12/17/25 - Staff would monitor the resident for signs/symptoms of infection. The resident's care plan in the EHR lacked any indication R11 required a catheter or catheter care until 01/12/26, even though the resident required the use of an indwelling catheter since his admission to the facility on [DATE].On 01/12/26 the care plan instructed the following:The resident required a foley catheter, 16 French (Fr) The resident would show no signs or symptoms of urinary infection through review date.Staff would position the resident's catheter bag and tubing below the level of the bladder and away from entrance room door. Staff would check catheter tubing for kinks [# TIMES] each shift. (The care planned intervention lacked the actual number of times staff were to check for kinks in the tubing.)Staff would monitor the resident for signs/symptoms of discomfort upon urination and frequency. Staff would monitor/document if the resident had pain/discomfort due to catheter use. Staff would monitor/record/report to the resident's physician signs/symptoms of urinary tract infection including pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, changes in behavior, and changes in eating patterns. The resident's care plan further lacked any (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indication R11 required 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) until 01/12/26, even though the resident required the use of an indwelling catheter since his admission to the facility on [DATE]. The care plan instructed the following:Staff would know the resident required EBP for the use of an indwelling device (foley catheter).The resident will be free from infection through the review date. Staff would use gown and gloves for all highˆcontact care activities (dressing, bathing, toileting, transferring, wound care, device care, changing linens/briefs) for residents with chronic wounds, indwelling medical devices, or known multidrug resistant organism (MDRO) colonization/infection. Review of the resident's Orders in the EHR revealed the following:08/19/25 (discontinued 09/03/25) - Urinary Catheter: Staff were to monitor urinary output every shift and provide catheter care every shift and as needed. 09/12/25 - Staff would provide catheter care and monitor foley catheter output every shift. 16 Fr. (indicating the size of catheter the resident required). Staff would monitor the resident's catheter two times a day for output related to neuromuscular dysfunction of the bladder.10/09/25 - Staff would change the resident's catheter as scheduled, every 30 days and as needed. The resident required a16 Fr catheter, with15 cubic centimeter balloon related to neuromuscular dysfunction of the bladder.01/08/26 - Cephalexin (antibiotic medication) Oral Tablet 500 milligram (mg). Staff were to give the resident one tablet by mouth four times a day for urinary tract infection for 7 Days.01/12/26 - Staff would assess the resident for adverse reaction, elevated temperature, and other pertinent information regarding his antibiotic treatment. Staff may make prog[res] note on this task screen. The resident required an antibiotic until 01/15/26 and the note instructed staff to document on the resident until 01/17/26. Staff would assess and write a progress note regarding the resident's use of antibiotics for treatment of a urinary tract infection, every day and night shift for urinary tract infection until 01/17/26 Review of the 08/13/25 hospital referral sheet for admission to the facility revealed R11 had a Methicillin-resistant Staphylococcus aureus (MRSA) infection dated 08/08/25. The referral noted a Dermatology consultation note dated 08/07/25 revealed R11 had a nearly continuous MRSA infection for more than a year. The resident had ten aerobic cultures from 10/2024 to the 08/07/25 date and all grew MRSA. Upon examination the assessor revealed their impression was that the resident had MRSA with bulla (blister) and crusts (dried serum and blood after a blister ruptures). The plan was to treat with appropriate antibiotics and to consider investigating home living situation to determine the source of recurring infection. The 08/30/25 at 12:43 PM Behavior Note revealed the resident called 9-1-1 and stated he had not eaten in six days. Emergency Management Service (EMS) called the nursing office phone to inquire if the resident needed an ambulance. The resident's physician gave permission to send the resident to the hospital. Review of the 08/30/25 at 01:38 PM Transfer to Hospital Summary revealed Emergency Medical Services (EMS) arrived at the facility to take the resident to the hospital. R11 had agitation behaviors. Review of the 08/30/25 at 02:01 PM Communication with Hospital Note revealed the facility called the hospital to give report and stated the resident refused all blood glucose checks/diabetes management this day, was increasingly more agitated with staff, and had a history of throwing objects. The resident had several wounds and was infected with MRSA. The resident had independently called 9-1-1 several times and verbalized he wanted to leave the facility via ambulance. Review of the 08/30/25 at 06:35 PM Health Status Note revealed the hospital called the facility and reported the resident was admitted due to UTI and low blood pressure. The hospital started the resident on antibiotics and provided maintenance fluids. The hospital also performed blood and urine cultures. Review of the 09/02/25 Updates From [local] Hospital revealed the resident had a UTI and multiple skin wounds and admitted to the hospital for intravenous antibiotics. The note further revealed the resident received Rocephin (antibiotic) in the Emergency Department and had yeast noted in his urine and was started on Fluconazole (antifungal medication). The note stated due to the extensive wounds (to both inner thighs and the left lateral legs), UTI, weakness, and inability to care for himself it would likely be an extended hospitalization. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident reported having wounds and the facility not doing anything specific for the wound care, besides just replacing bandaids. The writer noted they would have social work consult and the resident would prefer a different nursing home, if possible. The note stated the resident denied pain, generally did not feel well and felt very weak. Review of the 09/03/25 at 06:30 PM Health Status Note revealed the resident returned to the facility from the hospital. Review of the 01/07/26 at 02:11PM Order Note revealed a possible drug allergy for Cephalexin Oral Tablet 500 MG (Cephalexin) staff were to give 1 tablet by mouth four times a day for UTI for 7 Days Review of the 01/07/26 at 02:34 PM Order Note revealed the hospital clinic called this day to inform this nurse that resident culture and sensitivity results came back, and he has been prescribed a new antibiotic treatment order, previous antibiotic order discontinued. See orders tab for details. An interview/observation with R11 on 01/13/26 at 02:50 PM revealed the resident lying in bed in his room. His catheter hung on his bedside commode to the right side of bed. The resident had approximately 1000 milliliters (ml) of clear urine in the collection bag. The resident was awake and when asked about catheter care he laughed and stated no they never have done any catheter care for me. R11 reported staff had unclogged the catheter, but they did not clean the tube or area around it, where the tube enters, no they never clean any of that. R11 reported the catheter became clogged because he got stuff in the tube and bag. The resident reported every time he went to the hospital, he found out he had a UTI. R11 reported he knew when he had a UTI because the white stuff in the catheter gets thicker and it clogs, they don't ever test me for it here, I find out when I go to the hospital. R11 denied having any peri-care provided by facility staff. The resident reported he did not have an anchor for his catheter because he did not like the ones that suck as they pulled his skin. He requested a Velcro anchor, and the facility had not provided one as of the time of this interview. R11 stated he gave up asking for it [the anchor]. During an interview on 01/11/26 at 05:53 PM with Certified Medication Aide (CMA) BB reported there was not always enough staff to attend to resident needs. A confidential interview (date and time withheld to protect anonymity) revealed they did not feel like there were enough staff to monitor and meet the resident's needs. They reported resident checks, assistance, and cares lacked as a result of continued staffing problems. They stated they try to perform the duties assigned to them but could not always get it done and it impacted the residents. The CNA requested anonymity due to fear of retaliation for any concerns brought to facility administration. A confidential interview (date and time withheld to protect anonymity) revealed there were not enough staff to get things done. They reported the only resident who required them to have another staff member go in with them was R11 (the care plan lacked any documentation R11 required two staff to enter the resident's room for any reason). The staff member stated she did not report anything to Administrative Staff B due to fear of retaliation. During an interview with Licensed Nurse (LN) W on 01/13/26 at 06:30 PM revealed the last time the resident went to the hospital was the 1st time he had a UTI. He was not surprised the resident had infections as staff witnessed him picking his catheter with a knife at times. (The resident's record lacked evidence scraping of the catheter with a knife was charted and/or care planned interventions related to this). Staff managed R11's catheter by dumping and cleaning it. It was both the Certified Nurse Aides and LNs responsibilities to provide catheter cares. During an interview and review of infection control records on 01/12/26 at 03:44 PM Consultant Nurse C reported she found an Infection Control Binder dated 2024 and one dated 2025, which lacked any tracking of infections, antibiotic review, and/or infectious agent or organism involved. Consultant Nurse C provided an electronic charting software generated report titled Infection Surveillance Monthly Report indicating rises and falls acquired infections from February 2025 to January 2026. Consultant Nurse C stated the chart indicated the facility was possibly tracking and trending infections, however it lacked specific locations of the infections (resident room location in the building), infectious organisms, notation that at least one resident had a catheter and associated urinary tract infection, system for recording any infection control incidents with follow up/actions taken and/or where the infection originated (wound, dental, respiratory tract, etc.) Review of the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Catheter Care Policy dated 06/26/24 revealed it was the policy of the facility to ensure residents with indwelling catheters received appropriate catheter care and maintained their dignity and privacy when indwelling catheters were in use. The policy directed staff to provide catheter care every shift and as needed, leg bags would be attached to the resident's thigh or calf making sure to have slack on the tubing to minimize pressure and tension. Staff were to empty drainage bags when the bag was half full or every 3-6 hours. Staff were further directed to gently grasp penis, draw foreskin back if applicable, clean the meatus with clean cloth moistened with water and cleanser using a circular motion, clean down the shaft of the penis, with a new cloth staff were to start at the urinary meatus moving outward, and dry the area with a towel.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 14 residents, with one resident reviewed for dialysis (blood purifying treatment given when kidney function is not optimum). Based on observation, record review, and interviews, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and failed to complete assessments after dialysis for Resident (R) 27. Findings included:- R27's electronic medical record (EMR) documented diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and chronic kidney disease stage 4 (CKD - kidneys are moderately or severely damaged and are not properly filtering waste from the blood). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R27 required partial to moderate assistance for sit to stand, chair, bed, toilet, and shower transfers. The MDS documented R27 required substantial to maximal assistance for toileting and bathing. The MDS documented R27 was not receiving dialysis services. R27's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 08/11/25 documented R27 changing cognitive status and mood decline as possible underlying problems that may affect function. R27's 08/01/22 Care Plan documented R27 had a potential nutrition problem related to dialysis three times a week. R27's 03/06/23 Care Plan documented R27 had end stage disease requiring dialysis. The Care Plan documented the following interventions:08/24/24 - Directed staff to check the fistula (abnormal passage from an internal organ to the body surface or between two internal organs) in left upper extremity (LUE) for bruit (blowing or swishing sound heard when blood flows through a shunt) and thrill (a fine vibration felt which reflects the blood flow by a dialysis resident's shunt) each shift; notify physician if absent03/06/23 - Staff would know R27 went to dialysis Monday, Wednesday, and Friday, with a chair time of 09:30 AM. R27's 07/01/24 Care Plan documented R27 had potential fluid deficit related to diuretic (medication to promote the formation and excretion of urine) use. The Care Plan documented the flowing interventions:07/01/24 - Staff were to ensure R27 has access to adequate fluids whenever possible and ensure to check for fluid restrictions from dialysis.10/11/24 - Staff would know R27's weight was to be done pre and post dialysis. R27's Care Plan lacked direction to the staff related to dialysis communication sheets. A Physician's Order, dated 08/24/24, documented the resident required dialysis three times a week on Monday, Wednesday, and Fridays. The order documented a chair time of 09:30 AM. A Physician's Order, dated 08/26/24, documented the resident required pre-dialysis vital signs, weight, and assessment in the morning every Monday, Wednesday, and Friday. A Physician's Order, dated 08/26/24, documented post dialysis vital signs, weight, and assessment in the evening every Monday, Wednesday, and Friday. A Physician's Order, dated 04/09/23, directed staff to check the resident's fistula, check for bruit and thrill every shift in the resident's left upper extremity, every day and night shift. Review of the EMR under the Miscellaneous tab lacked any signed dialysis communication sheets scanned into the clinical record after 12/01/25. Review of R27's Dialysis Communication Sheets were reviewed from 11/14/25 to 01/14/26. The communication sheets lacked documentation from the dialysis center on 11/23/25. The communication sheets further revealed incomplete documentation from the dialysis center on 11/17/15, 11/19/25, 11/25/25, 12/01/25, 12/08/25, 12/10/25, 12/15/25, 12/17/25, 12/19/25, 12/21/25, 12/23/25, 01/05/26, 01/07/26, and 01/14/26. The communication sheets revealed no post dialysis documentation from the facility on 12/17/25, 12/21/25, and 12/23/25. R27's EMR lacked Dialysis Communication Sheets scanned into the clinical record and the facility was unable to provide dialysis communication sheets for the following dates: 11/21/25, 12/03/25,12/05/25, 12/12/25, 01/07/26, and 01/09/26. On 01/14/26 at 05:07 PM, an observation revealed R27 sat in a wheelchair in the dining room. On 01/14/26 at 04:59 PM, Licensed Nurse (LN) S stated before a resident left the facility for their dialysis appointment, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff would fill out a dialysis communication sheet that included the date, resident's weight, and vitals. LN S stated dialysis fills out their portion as well. LN S stated when the resident returned, staff get weight, and vitals. Staff would also check if the resident was alert and oriented and document any changes. LN S stated all of the information was documented on the communication sheet. LN S further stated the facility did not have a medical records person at the time, but they would like to have them all scanned in the chart. LN S stated staff were supposed to chart their assessment in the Treatment Administration Record (TAR). LN S stated the EMR populates an area for staff to chart pre and post assessment information. LN S further stated the assessment information should be charted in the EMR and on the dialysis communication sheets. LN S stated the assessment should not just be staff documenting vitals in the EMR. On 01/14/26 at 05:44 PM, Consultant Nurse C stated dialysis sheets should be in a binder with the communication forms. Consultant Nurse C stated the forms need to be filled out with pre dialysis vitals, and weights. Consultant Nurse C the binder should go with the resident to dialysis, dialysis staff should fill out their section and send it back. Consultant Nurse C stated staff should be doing pre and post vitals in the facility and they need to keep the dialysis sheets. Consultant Nurse C stated the dialysis communication sheets needed to be filled out top to bottom and completely, if something did not apply then it should have been marked that it did not, but it needed to be completed. Consultant Nurse C stated after the sheets were completed, they needed to be uploaded into the resident's profile. Consultant Nurse C stated she saw no reason for the communication sheets to have blank areas, and they needed to be completed in their entirety. The facility's Dialysis policy, revised 03/18/22, documented the facility will ensure that each resident receives care and services for the provision of dialysis consistent with professional standards of practice including the ongoing assessment of resident's condition and monitoring for complications before and after dialysis treatments received at certified dialysis facility. Ongoing assessment and oversight of the resident before and after dialysis treatments. Ongoing communication and collaboration with the dialysis clinic, regarding care and services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 14 residents. Based on observations, record review, and interviews, the facility failed to provide trauma-informed, individualized care including implementing a resident-specific care plan with identified triggers and interventions related to past trauma for Resident (R) 1. Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The admission Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 had no behaviors. The Quarterly MDS dated [DATE] documented R1 had a BIMS score of nine, which indicated moderate cognitive impairment. R1 had no behaviors. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated [DATE] lacked an analysis of findings. R1's [DATE] Care Plan documented R1 had impaired cognitive function and impaired thought processes related to dementia. The Care Plan documented the following interventions:[DATE] - Staff administered medications as ordered and monitored for side effects and effectivenessXXX[DATE] - Staff communicated with R1, her family, and caregivers regarding R1's capabilities and needsXXX[DATE] - Staff kept R1's routine consistent and tried to provide consistent caregivers as much as possible in order to decrease confusionXXX[DATE] - Staff monitored, documented, and reported as needed, any changes in cognitive functionXXX[DATE]- Staff provided R1 with reassuring responses to allow R1 to feel safeXXX[DATE]- Staff used a calm, gentle approach, and explained to R1 about any problems or actions that took place. The care plan did not address R1's past trauma. R1's [DATE] Care Plan documented R1 accused people of taking her money even though R1 had the card in her possession. That behavior was due to a past experience of her family taking her money. The Care Plan documented the following interventions:[DATE]- Staff administered medications as ordered. Staff monitored and documented for side effects and effectivenessXXX[DATE]- Staff anticipated and met R1's needsXXX[DATE]- Staff assisted R1 to develop more appropriate methods of coping and interacting. Staff encouraged R1 to express her feelings appropriatelyXXX[DATE]- Staff discussed R1's behavior with her when reasonable and explained why her behavior was inappropriate or unacceptable to R1XXX[DATE]- Staff intervened when necessary to protect the rights and safety of others. Staff approached R1 in a calm manner, diverted her attention, and removed R1 from the situation as neededXXX[DATE]- Staff provided R1 with a program of activities to her interests and accommodated R1's status. The care plan did not address R1's past trauma. R1's [DATE] Care Plan documented R1 had the potential for a psychosocial well-being problem related to her bipolar disorder and dementia. The Care Plan documented the following interventions:[DATE]- Staff allowed R1 time to answer questions and to verbalize her feelings, perceptions, and fearsXXX[DATE]- Staff consulted with social services and psychiatric servicesXXX[DATE]- Staff provided opportunities for R1 and her family to participate in her careXXX[DATE]- When conflict arose, staff moved R1 to a calm, safe environment and allowed her to vent or share her feelings. The Care Plan did not address R1's past trauma. R1's EMR revealed the following: A Psych Initial Visit Note on [DATE] documented R1 stated she had seen psychiatry in the past and had been hospitalized for psychiatric reasons. The note documented R1 had diagnoses of bipolar disorder, dementia, and post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). A Trauma Informed Care Screen/Assessment on [DATE] documented R1 answered yes to the question of an experience of sexual assault with a note underneath that stated the sexual assault occurred during R1's childhood and she did not want to talk about it. A No Type Specified note on [DATE] at 05:09 PM documented the nurse provided comforting (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	talk related to R1's roommate passing away. R1 appeared to be grieving but she was not crying at that time. R1 stated she was thinking about her roommate. The nurse asked R1 if she felt she was processing okay and R1 stated she was okay and she had to think it through. The nurse let R1 know to let nursing or social services know if she needed anything. On [DATE] at 01:53 PM, R1 sat in her wheelchair in her room. She appeared to be upset and talking to herself. On [DATE] at 03:59 PM, Certified Nurse Aide (CNA) N stated she was not sure if the facility had any place that listed a resident's behaviors. She stated if a new aide came in, the facility did not have anything to tell them if a resident had behaviors. CNA N stated R1 got upset about money and obsessed over her money. She stated R1 had been more emotional since her roommate passed away last month and if anyone talked about it, R1 became upset. CNA N stated she felt like R1 losing her roommate was traumatic for her. On [DATE] at 05:04 PM, Licensed Nurse (LN) S stated R1 had yelling behaviors, and she became aggressive with staff. She stated R1 had more behaviors when her family visited. She stated she thought the social worker did the trauma assessments. On [DATE] at 05:16 PM, Social Services Designee (SSD) F stated she completed trauma assessments on admission under a section of the admission assessment that dealt with sexual and mental abuse. She stated if it triggered for trauma, she put it in the care plan. She stated if she knew about another incident that occurred, she would complete another trauma assessment. SSD F stated after R1's roommate died, she did not think she completed a trauma assessment on her or put anything in her care plan. She stated immediately after her roommate died, R1 was upset but she had not noticed any big behavior changes in R1 after it happened. On [DATE] at 05:45 PM, Consultant Nurse C stated the facility completed a trauma assessment if a resident started having behaviors or acted out because maybe something triggered them, and the facility needed their history. She stated if a resident triggered for trauma on a trauma assessment, the resident needed an individualized care plan for trauma and a safety plan.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 14 residents with one reviewed for dementia care. Based on observations, record review, and interviews, the facility failed to provide dementia care and services for Resident (R) 1 when the facility failed to assess, identify, record, respond to, and reassess R1's specific behaviors and triggers to promote an environment, which supported R1's individualized care needs. Findings included:R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The admission Minimum Data Set (MDS) dated 03/17/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 had no behaviors. R1 preferred reading books, newspapers, or magazines, listening to music, being around animals such as pets, doing things with groups of people, participating in her favorite activities, and spending time outdoors. The Quarterly MDS dated 12/02/25 documented R1 had a BIMS score of nine, which indicated moderate cognitive impairment. R1 had no behaviors. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/29/25 lacked an analysis of findings. R1's 03/29/25 Care Plan documented R1 had impaired cognitive function and impaired thought processes related to dementia. The Care Plan documented the following interventions:03/29/25 - Staff administered medications as ordered and monitored for side effects and effectiveness.03/29/25 - Staff communicated with R1, her family, and caregivers regarding R1's capabilities and needs.03/29/25 - Staff kept R1's routine consistent and tried to provide consistent caregivers as much as possible in order to decrease confusion.03/29/25 - Staff monitored, documented, and reported as needed, any changes in cognitive function.03/29/25 - Staff provided R1 with reassuring responses to allow R1 to feel safe.03/29/25 - Staff used a calm, gentle approach, and explained to R1 about any problems or actions that took place. The care plan did not address individualized behaviors, triggers, and interventions for R1's dementia diagnosis and related behaviors. R1's 03/29/25 Care Plan documented R1 accused people of taking her money even though R1 had the card in her possession. That behavior was due to a past experience of her family taking her money. The Care Plan documented the following interventions:03/29/25 - Staff administered medications as ordered. Staff monitored and documented for side effects and effectiveness.03/29/25 - Staff anticipated and met R1's needs.03/29/25 - Staff assisted R1 to develop more appropriate methods of coping and interacting. Staff encouraged R1 to express her feelings appropriately.03/29/25 - Staff discussed R1's behavior with her when reasonable and explained why her behavior was inappropriate or unacceptable to R1.03/29/25 - Staff intervened when necessary to protect the rights and safety of others. Staff approached R1 in a calm manner, diverted her attention, and removed R1 from the situation as needed.03/29/25 - Staff provided R1 with a program of activities to her interests and accommodated R1's status. The care plan did not address individualized triggers and interventions for R1's dementia diagnosis and related behaviors. R1's 09/05/25 Care Plan documented R1 had the potential for a psychosocial well-being problem related to her bipolar disorder and dementia. The Care Plan documented the following interventions:09/05/25- Staff allowed R1 time to answer questions and to verbalize her feelings, perceptions, and fears.09/05/25- Staff consulted with social services and psychiatric services.09/05/25- Staff provided opportunities for R1 and her family to participate in her care.09/05/25- When conflict arose, staff moved R1 to a calm, safe environment and allowed her to vent or share her feelings. The care plan did not address individualized behaviors, triggers, and interventions for R1's dementia diagnosis and related behaviors. R1's 01/06/26 Care Plan documented R1 had little, or no activity involvement related to staying in her room most of the day (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and doing her own self-motivated activities. The Care Plan documented the following interventions:01/06/26- Staff encouraged R1 to participate in group activities.01/06/26- Staff provided R1 with a monthly calendar.01/06/26- R1 watched television in her room. The care plan did not address R1's individual preferences for activities. R1's EMR revealed the following: An Orders-Administration Note on 08/22/25 at 10:18 PM, documented R1 stated she was not checking her blood sugar until the [expletive] in the office gave her money. A Behavior Note on 08/23/25 at 01:18 PM, documented R1 refused vital signs and blood glucose check that shift. R1 let the staff check her oxygen saturation after the smoke break. R1 stated she was mad about her money. An Activity Progress Note on 09/07/25 at 03:44 PM, documented R1 enjoyed coming out to most activities offered depending on how she felt that day. R1 attended all four smoke times offered each day and she attended bingo and nail time. A Behavior Note on 10/17/25 at 12:37 PM, documented R1 sat in her wheelchair in the lobby yelling out profanities. A Behavior Note on 10/20/25 at 10:49 AM, documented R1 yelled out in the hallway, not directed at any person aside from staff at times when they walked by. The nurse asked R1 what was wrong and R1 stated no, [expletive] you, [expletive] all of you, her cousin needed to get out of the facility and R1 was a changed woman. The nurse asked R1 if something happened to make her upset and R1 stated to the nurse to shut the [expletive] up, she was not talking to any of them. The nurse attempted to redirect R1. R1 became more upset and agitated with the redirection attempt. R1 wheeled herself back to her room and continued yelling. A Behavior Note on 10/20/25 at 10:56 AM, documented the staff offered R1 a shower that shift and she refused. The staff educated R1 on the importance of routine hygiene for physical and mental well-being. R1 continued to refuse and continued yelling in her room. The nurse educated R1 to let nursing staff know if she changed her mind or wanted a shower on a different day. R1 refused to acknowledge education or the nurse who spoke to her. The nurse left R1's room as to not further escalate R1's yelling. An Orders- Administration Note on 10/20/25 at 11:54 AM, documented R1 refused medication and yelled at staff. The facility made R1's primary care physician aware with no changes at that time. The staff continued to offer medications as scheduled. An Orders-Administration Note on 10/21/25 at 11:11 AM, documented R1 refused her lorazepam (antianxiety medication- medication used to treat anxiety [mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear]) medication. The staff educated R1 on the importance and reason for the medication ordered. R1 yelled and cussed at staff then continued to refuse the medication. The facility made R1's primary care physician aware with directions for staff to continue to encourage R1 to comply with medication administration. A No Type Specified note on 12/22/25 at 05:09 PM, documented the nurse provided comforting talk related to R1's roommate passing away. R1 appeared to be grieving but she was not crying at that time. R1 stated she was thinking about her roommate. The nurse asked R1 if she felt she was processing okay and R1 stated she was okay and she had to think it through. The nurse let R1 know to let nursing or social services know if she needed anything. A Behavior Note on 12/30/25 at 12:02 PM, documented R1 yelled out in the front room that she knew the facility had her money and to give her the money. The nurse explained to R1 that she had her own money on her debit card and no facility staff had access to it. R1 continued to yell out and stated to watch her [expletive] them up, watch her [expletive] them all up. The nurse attempted to talk and redirect R1 without success. R1 continued to scream and cuss at staff in the front room. The nurse redirected R1 to her room for about three minutes, at which point, R1 self-propelled back out to the commons area, cussing but not yelling down the hallway. The nurse continued with redirection techniques. On 01/13/25 at 01:53 PM, R1 sat in her wheelchair in her room. She appeared to be upset and talking to herself. On 01/14/26 at 10:16 AM, R1 sat in her wheelchair in the day area. She had a coloring page and some colored pencils/markers in front of her in a closed package. R1 did not engage in the coloring activity. On 01/14/26 at 10:23 AM, R1 sat in her wheelchair in the day area. She appeared to be upset with an unidentified staff member. On 01/14/26 at 03:59 PM, Certified Nurse Aide (CNA) N stated dementia care varied by person and staff redirected residents with (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors as much as they could. She stated she was not sure if the facility had any place that listed a resident's behaviors. She stated if a new aide came in, the facility did not have anything to tell them if a resident had behaviors. CNA N stated R1 got upset about money and obsessed over her money. She stated R1 thought her family took her money and she started packing her stuff while stating she was getting out of the facility. She stated if R1 saw someone come out of the business office with money, it triggered her. She stated there was a housekeeper that had a good connection with R1 who was able to calm her down. On 01/14/26 at 05:04 PM, Licensed Nurse (LN) S stated when a resident had behaviors, the staff documented to identify their behaviors and what redirections worked for them. She stated staff knew what behaviors a resident had through the progress notes and in the care plan. LN S stated the care plan should have individualized behaviors, triggers, and interventions. She stated the CNAs had access to the care plans and they received education on how to access them. LN S stated R1 had yelling behaviors, and she became aggressive with staff. She stated R1 had more behaviors when her family visited. On 01/14/26 at 05:45 PM, Consultant Nurse C stated she expected dementia care to be specialized to address the residents' different needs. She stated the care plans should list behaviors, triggers, and interventions for individual residents and staff knew the behaviors through the care plans. The facility's Dementia Care Policy last revised 06/26/24, directed the facility assessed, developed, and implemented care plans through an interdisciplinary team approach that include the resident, their family, and/or resident representative, to the extent possible. The policy directed the care plan interventions were related to each resident's individual symptomology and rate of dementia progression. The policy directed care, and services were person-centered and reflected each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. The policy directed the facility utilized individualized, non-pharmacological approaches to care to include meaningful activities aimed at enhancing the resident's well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175323	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nortonville Health Care Center	412 E Walnut St Nortonville, KS 66060

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. The facility reported a census of 34 residents with 14 residents included in the sample. Based on observation, interview, and record review the facility failed to ensure Resident (R) 7, who had a history of sepsis, received needed dental care and services. R7 refused her dental visit on 10/30/25. The record lacked evidence of staff attempts to get R7 to a dentist after her 10/30/25 refusal, and approximately two months R7 began complaining of tooth pain. The records revealed R7 had an infection to her left lower molar, which caused her pain, affected her eating, and required antibiotics to treat. Findings included: - The Electronic Health Record (EHR) revealed the resident diagnoses included pain and sepsis. Review of the 08/11/25 Annual Minimum Data Set (MDS) revealed R7 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS documented the resident had no rejection of care and was dependent on staff for most of her activities of daily living (ADL). The resident received scheduled pain medication, as needed (PRN) pain medication, and non-medication interventions for pain. The 08/11/25 Care Area Assessment regarding Cognitive Loss/Dementia, Functional Abilities (Self-Care and Mobility), Psychosocial Well-Being, and Mood State all lacked development and contained the following work up by the facility in each: wctm - indicating the facility will continue to monitor. The Care Plan for R7 revealed an intervention initiated 11/19/18, revised 02/04/25, and included R7 had her own teeth, and staff were to set up supplies for her to brush her teeth, twice a day. Review of the 05/13/25 H&P-New Admit Note revealed the resident admitted to Long-Term Care under the services of Physician KK. The note listed R7's medications as:Hydrocodone (narcotic pain medication used to treat moderate to severe pain) 5 mg-acetaminophen 325 mg tablet, one by mouth (PO) every 6 hours (Q6H) as needed (PRN) pain emergency fill.Hydrocodone 5 mg-acetaminophen 325 mg tablet, one by mouth (PO) every 6 hours (Q6H) as needed (PRN) pain. Review of the Progress Note-Monthly Note electronically signed by Physician KK on 07/23/25 revealed the resident was seen in her room for a monthly regulatory visit. The note revealed the resident continued to do well in the facility, denied any excessive pain, fever, chills, or other issues at the time. The note listed two medications for R7 in the medications section, and both were for hydrocodone 5 mg-acetaminophen 325 mg one tablet by mouth every 6 hours for as needed pain and the second entry one tablet by mouth every 6 hours as needed for pain emergency fill. Review of the 10/15/25 at 09:25 AM N Adv - AIMS Evaluation revealed the resident does not currently have problems with teeth. Review of the 10/30/25 at 12:43 PM Social Services Progress Notes revealed R7 refused to see 360 dental today. The EHR revealed no further Progress Notes regarding 360 dental or dental appointments for R7. Review of the 12/30/25 at 10:40 AM Order Note revealed the Penicillin V Potassium Oral Tablet 500 MG, give 500 mg by mouth two times a day, for dental infection for 5 days. Review of the 12/30/25 at 10:42 AM No Type Specified note revealed R7 complained of dental pain and had redness and some swelling to her left lower molar tooth. The note documented an order was written. Review of the 01/08/26 at 01:53 PM N Adv Skilled Evaluation revealed R7 had complaints of pain and discomfort to her lower left jaw, noted singular tooth in place with inflamed gums surrounding tooth, and oral care provided by the writer that day. The evaluation noted the resident had mouth or facial pain, discomfort or difficulty with chewing. Observation on 01/14/26 at 01:32 PM revealed R7 laid in bed in her room and picked her teeth with her fingernails. R7 stated her bottom left tooth in the back was hurting her, and it hurt to eat for the last two weeks. R7 stated she grinds her teeth and would like to see the dentist, as they gave her numbing gel, but it did not really help. During an interview with Certified Nurse Aide (CNA) N on 01/14/26 at 03:59 PM revealed if a resident complained of dental pain, they would tell the Social Services Designee and noted the facility had a dentist that visited every 3 months but would come out for emergency visits. CNA N stated about 2 weeks ago R7 was having a hard time eating and holding her mouth and said her tooth hurts, on a single tooth, gums swollen and red. The nurse checked it out and SSD said they would contact the dental group, but CNA N did not know if they came out or not, but knew the tooth (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was still there and hurting R7 really bad. CNA N said she talked to hospice and the SSD about R7 still hurting. CNA N stated if a resident complained of pain in general, she informed the nurse and if Tylenol (acetaminophen) was needed the staff told the medication aide or use BioFreeze or lidocaine patch and let the nurse know if the resident still complained of pain. CNA N stated R7 was doing better, but her tooth was bothering her a lot. During an interview on 01/14/26 at 05:04 PM, Licensed Nurse (LN) S said if a resident complained of dental pain the staff reported it to the doctor, looked at it, and checked if they can get the resident to see a dentist. LN S said they were going to try and get R7 into a dentist, noted R7 had complained about generalized pain, sometimes would tell staff different things. LN S stated if a resident complained of pain, she assessed them for what kind of pain, see if chronic or new to them, if new would assess further for any injury. LN S said if the resident had a PRN medication ordered she would offer it. LN S said R7 complains of pain everywhere or sometimes it was her back. LN S said R7 had a PRN pain medication, but yesterday it was changed to scheduled. During an interview with Consultant Nurse C on 01/14/25 at 05:45 PM revealed she expected the charge nurses to update the care plan. Consultant Nurse C stated special needs should be care planned. She stated the care plan should list behaviors, triggers, and interventions for individual residents, and staff should know through care plans how to get into the care plan to provide the best care. Consultant Nurse C stated the care plans should be as individualized as possible to provide the best care, including ADLs. Review of the facility provided Dental Services Policy, dated 11/06/23, revised 06/24/24, revealed emergency dental services included services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. The policy noted all actions and information regarding dental services, including any delays related to obtaining dental services, would be documented in the resident's medical record. The policy noted the SSD maintained contact information for providers of dental services that were available to facility resident at a nominal cost.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility had a census of 34 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure the number of nursing (licensed and unlicensed) staff and actual hours worked were posted for all four days of the onsite survey. The facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months. Findings included:- On 01/11/26 at 01:45 PM, an observation revealed the daily nursing staff numbers and hours were not posted in the facility. On 01/12/26 at 12:31 PM, an observation revealed the daily nursing staff numbers and hours were not posted in the facility. Review of daily posted staffing records revealed the facility did not have daily posted staffing sheets after 09/30/25. On 01/12/26 at 04:03 PM, Administrative Staff A stated the facility did not have the daily staffing posted. Administrative Staff A slapped her hand on the wall next to her and stated it normally goes right here, but we do not have it. Administrative Staff A stated, I am just being honest with you; we do not have it. On 01/13/26 at 02:13 PM, Administrative Staff A stated the facility only had daily posted staffing until September 2025. Administrative Staff A stated the facility switched to timesheets to show there was staffing. She stated they started posting staffing sheets the day prior. She further stated she knew there were more staffing sheets but did not know where they were. She stated it used to be the Minimum Data Set (MDS) staff that posted the staffing sheets; however, the facility lost their MDS budget, and that responsibility transferred to the Director of Nursing. Administrative Staff A stated the night nurse would now be responsible to fill them out and post them. The facility's Nurse Staffing Posting Information Policy, revised 06/26/24, documented it was the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The facility would post the Nurse Staffing Sheet at the beginning of each shift. Nursing schedules and posting information would be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever was greater.